108 Kings Highway East . Suite 220 . Haddonfield . NJ 08033 . 856.216.0211 . Fax: 856-295-8727

Personal Information

Name:	Sex: Male Female	Marital Status: S M D W

SSN:	Date of birth:	Email:

Home address:	Height:	Weight:

City:	State:	ZIP Code:	Birth Country or State:

Driver's License #: State:	Home Phone:	Cell Phone:
Annual Earned Income: $	Annual Unearned Income: $	Net Worth: $
U.S. Citizen: Yes No	*If not U.S.A., date of entry:*	Type of Visa:

Owner Name(*if other than insured*):	Relationship:	DOB/DOT:	SSN/TIN:
Primary Beneficiary Name:	Relationship:	DOB:	SSN:
Contingent Beneficiary Name:	Relationship:	DOB:	SSN:

What is the purpose of the insurance (Protection of Family, Estate Planning, Business, etc.)?

Have you applied for life insurance in the past 90 days? Yes No If yes, list company name and amount:

Are you a member of the armed forces including reserves? Yes No If yes, give full details:

Employment Information

Employer:

Employer address:	Length of Employment:

City, State:	ZIP Code:	Phone #:

Occupation:	Duties:

Background Information

Have you ever used any tobacco products? Yes No	*If yes, what type and frequency of use/amount:*	*Date of last use?:*
Do you engage in regular exercise? Yes No	*If yes, give details of type, frequency and length of time:*	

Does your driving history contain any moving violations or license suspensions in the past 5 years? Yes No *If yes, provide details and state*:

____

Do you have any life insurance/annuities currently in force? Yes No *If yes, provide company name, total face amount, year issued, policy #*

____

Do you participate in any avocation activities? Yes No Sky Dive, Pilot an Aircraft, Mountain Climb, Scuba Dive, Hang Glide, Auto Racing, etc…

*If yes, explain; include pilot ratings, licenses held, etc.*____

Do you consume alcohol? Yes No	*If yes, what type and frequency of use/amount:*	*Date of last use?:*

Do you intend to travel or reside outside of the United States or Canada with the next two years? Yes No *If yes, country, purpose, and date:*

____

Family History

Family Health History:	Age if living	Age at death if deceased & reason	History of heart disease, stroke, circulatory disorder, kidney disease? If yes, explain	History of cancer? If yes, explain
Mother:	________	______________	Yes No ________	Yes No ________
Father:	________	______________	Yes No ________	Yes No ________
Brother:	________	______________	Yes No ________	Yes No ________
Brother:	________	______________	Yes No ________	Yes No ________
Sister:	________	______________	Yes No ________	Yes No ________
Sister:	________	______________	Yes No ________	Yes No ________

Medical History – Please complete with all known information

Primary Physician:		Phone:
Date last seen:	Reason and Findings:	
Current address:		
City:	State:	ZIP Code:
Please list ALL other physicians seen over the past five years, including any specialists (attach additional page if necessary):		
Physician:		
Date last seen:	Reason(s) Seen:	Phone:
Current address:		
City:	State:	ZIP Code:
Physician:		
Date last seen:	Reason(s) Seen:	Phone:
Current address:		
City:	State:	ZIP Code:
Physician:		
Date last seen:	Reason(s) Seen:	Phone:
Current address:		
City:	State:	ZIP Code:
In what clinics, hospitals, or sanitariums you have *ever* been treated (attach additional page if necessary):		
Name:		Dates spent:
Reason(s) seen:		
Name:		Dates spent:
Reason(s) seen:		

Please list ALL current medications:

____

____

Continued answers from above:

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:	Yes	No
Chest pain, shortness of breath, heart murmur, blood pressure, stroke, irregular heartbeat, or any other disease or disorder of the heart or arteries?	☐	☐
Diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system?	☐	☐
Mental, seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including anxiety, depression or other psychiatric conditions?	☐	☐
Arthritis, gout, connective tissue disease or other bone, joint, muscle or skin disorder?	☐	☐
Asthma, bronchitis, sleep apnea or other breathing, emphysema or any lung disorder?	☐	☐
Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine?	☐	☐
Prostate or testicular disease, disease of the uterus, ovaries or breast?	☐	☐
Anemia, leukemia, clotting disorders, or platelet disorders?	☐	☐
Disorder of the kidneys, bladder, prostate or reproductive organs or protein in the urine?	☐	☐
Cancer, tumors, masses, cysts or other such abnormalities?	☐	☐
An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance?)	☐	☐
Any other health impairment or medically treated condition not previously mentioned?	☐	☐
Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS TO THE QUESTIONS ABOVE IN THE SPACE BELOW. Attach additional pages if necessary. Please be specific with this information, and include phone numbers.

In Force Insurance

Total life insurance in force: $_________________

a. Will the new insurance replace any existing insurance? _____ yes ______ no

b. Total insurance currently pending with all companies $_______________

c. What is the total amount of insurance you intend to accept? $___________________

Company	Policy or Contract #	Face Amount	Year of Issue	Annual Premium	Cash Surrender Amount	To Be Replaced or Converted?
						Yes No
						Yes No
						Yes No
						Yes No

Total disability insurance in force: $_________________

a. Will the new insurance replace any existing insurance? _____ yes ______ no

b. Total insurance currently pending with all companies $_______________

c. What is the total amount of insurance you intend to accept? $___________________

Company	Policy or Contract #	Benefit Amount	Waiting Period	Type (P, E)*	Employer Paid	To Be Replaced?
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

*** P: Personally Owned, E: Employer Owned**

Financial Questions

Gross annual earned income (salary, commissions, bonuses, etc.)

$____________________ Spouse ______________

Gross annual unearned income (dividends, interest, net real estate income, etc.)

$____________________ Spouse ______________

Total assets $______________________ Spouse ______________

Total liabilities $___________________ Spouse ______________

Personal Net Worth $________________ Spouse ______________

New Policy Beneficiary Information (Primary or Secondary)

P

Name ____ Relation ___________________________

DOB _____________ SSN/TIN _________________________ Phone ____________________________

Address ____

P

S

Name ____ Relation ___________________________

DOB _____________ SSN/TIN _________________________ Phone ____________________________

Address ____

P

S

Name ____ Relation ___________________________

DOB _____________ SSN/TIN _________________________ Phone ____________________________

Address ____

Disability Information (complete if applying for disability)

Primary Occupation:		Hours worked per week:
Exact duties and percentage of time devoted to each:		
How many employees do you supervise?	How long have you been employed in your present occupation?	How long have you been employed by your present employer?
What is your percentage of ownership?	How long have you been an owner?	How long has the business been in existence?

Question		
1. Are you actively at work at least 30 hours per week in the above occupation?	Yes ☐ No ☐	**IF NO, give details below.**
2. Do you have any other full or part-time jobs?	Yes ☐ No ☐	**IF YES, give details below.**
3. Do you plan to change jobs in the next six months?	Yes ☐ No ☐	**IF YES, give details below.**
4. Are you aware of any fact that could change your occupational status or financial stability?	Yes ☐ No ☐	**IF YES, give details below.**
5. Have you had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated?	Yes ☐ No ☐	**IF YES, give details below.**
6. Have you EVER been convicted of, pled guilty to or no contest to, a felony or misdemeanor other than a traffic violation, or are any charges pending against you?	Yes ☐ No ☐	**IF YES, give details below.**
7. Has any application for life, health or disability insurance coverage on you ever been postponed or declined; or has any such coverage ever been issued other than as applied for, rescinded or required an additional premium?	Yes ☐ No ☐	**IF YES, give details below.**
8. Have you EVER had a professional license suspended, revoked, or is such license under review or have you ever been disbarred?	Yes ☐ No ☐	**IF YES, give details below.**
9. Are you currently disabled, or do you expect to be disabled?	Yes ☐ No ☐	**IF YES, give details below.**
10. Do you perform any of your current primary duties at your place of residence?	Yes ☐ No ☐	**IF YES, give details below.**
11. Have you received or applied for disability, workers' compensation, or military disability benefits from any source in the past 5 years?	Yes ☐ No ☐	**IF YES, give details below.**
12. In the last ten years have you consumed alcoholic beverages? If yes, date last used: Number of drinks per week: Type of Beverage:	Yes ☐ No ☐	
13. In the past 5 years, has any Acupuncturist, Chiropractor, Counselor, Health Facility, Personal/Primary Care Physician, Practitioner, Psychiatrist, Psychologist, Social Worker or Therapist examined or treated you?	Yes ☐ No ☐	**IF YES, give details below.**

PLEASE PROVIDE DETAILS TO ANY ANSWERS TO THE QUESTIONS ABOVE in the space below with the question number.
Attach additional pages if necessary.

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION - HIPAA COMPLIANT

____ ____________________

Name of Proposed Insured Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medication prescribed, and any other protected health information concerning me to the insurance companies and /or settlement companies names below. This includes information on the diagnoses and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes the information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that my agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the insurance companies and/or settlement companies named below may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision benefits; 4) administer coverage; 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance and /or settlement companies named below.

This authorization should remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the Office of the President of Advantage Insurance Network, INC.I understand that a revocation is not effective to the extent that any of My providers has already relied on this Authorization to disclose information about me or to the extent that the insurance and/or settlement companies named below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies named below except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization or release my complete medical record, the insurance and/or settlement companies named below may not be able to process my application, or if the coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

American General
AXA
Brighthouse Financial
Foresters Financial
Genworth
Global Atlantic
Guardian Life
John Hancock Lincoln
National Life
Massachusetts Mutual
Minnesota Life
Mutual of Omaha (United of Omaha)
Mutual of Omaha (Companion Life)
Nationwide
New York Life
OneAmerica
Pacific Life
Penn Mutual
Principal Life Insurance
Principal National Life
Protective Life
Prudential
Standard Insurance
Symetra
Transamerica Life
U.S. Life
Voya Financial
Zurich American
Advantage Insurance Network
Ashar Group LLC
Welcome Funds, Inc.
Rosenblatt Brokerage

_________________________________ ____________________

Signature of Proposed Insured Date