

INFORMATION NEEDED FOR LIFE INSURANCE APPLICATION OR QUOTE

1. FULL LEGAL NAME _____ MARITAL STATUS _____
2. HOME ADDRESS _____
3. DATE OF BIRTH _____ PLACE OF BIRTH _____ ARE YOU A U.S. CITIZEN? _____
4. EMAIL ADDRESS _____ CELL # _____ HOME # _____ WORK # _____
5. OCCUPATION _____ DUTIES _____ HOW LONG @ JOB? _____
6. EMPLOYER _____ EMPLOYER ADDRESS _____ ANNUAL INCOME _____
7. HAVE YOU FILED BANKRUPTCY IN THE PAST FIVE YEARS? IF YES, WHEN? _____
8. DO YOU HAVE ANY OTHER LIFE INSURANCE IN FORCE? _____ IF YES, NAME CARRIER, AMOUNT OF COVERAGE, AND WHEN ISSUED? _____
9. HAVE YOU EVER HAD LIFE INSURANCE DECLINED OR RATED? IF YES, EXPLAIN WHY? _____
10. WHO SHOULD BE NAMED AS YOUR PRIMARY BENEFICIARY? INCL: NAME, DATE OF BIRTH AND RELATIONSHIP: _____
11. ARE YOU A PILOT OR HAVE YOU EVER HELD A PILOT LICENSE? _____
12. DO YOU PARTICIPATE IN HANG GLIDING, SCUBA OR SKY DIVING, MOUNTAIN OR ROCK CLIMBING, RACE CARS, BOATS OR ANY OTHER HAZARDOUS HOBBY/SPORT? IF YES, WHAT AND HOW OFTEN: _____
13. DO YOU PLAN TO TRAVEL OR RESIDE OUTSIDE THE U.S.? _____ IF YES, WHERE, HOW OFTEN AND HOW LONG WILL YOU STAY? _____
14. ANY SPEEDING OR MOVING VIOLATIONS, DRIVING UNDER THE INFLUENCE, LIC SUSPENSION, RESTRICTION, REVOKED OR HAVE YOU EVER BEEN CONVICTED OF A FELONY? IF YES, PLEASE EXPLAIN: _____
15. HAVE YOU EVER USED TOBACCO IN ANY FORM? IF YES, WHAT & WHEN LAST USED: _____
16. PERSONAL PHYSICIAN _____ HT/WT _____ PLEASE LIST ALL PRESCRIPTIONS MEDICATIONS: _____
17. YOUR HEALTH: LIST ANY MINOR OR SIGNIFICANT HEALTH ISSUES IN THE PAST 10 YEARS: _____
18. FAMILY HISTORY: AGE OF LIVING PARENTS & SIBLINGS: _____
IF DECEASED: CAUSE OF DEATH & AGE AT TIME OF DEATH: _____

CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS: TOLL FREE: 1-877-826-2460 FAX: 1-317-826-2465

OUR EMAIL: staff@cangy.com