WIN Financial Agency

Insurance Application Intake Form

Life Insurance | New Business Application Intake

Fields marked * are required. If you answer Yes to any health or history question, complete the follow-up fields beside it.

CASE INFORMATION

Agent * | 2nd Agent | Carrier * | Product *

Face Amount ($) * | Monthly Premium ($) * | Draft Type: Select

Preferred Draft Day: Draft after approval (default) | Signing Method *: Select | Case Notes

BANK / PAYMENT INFORMATION

Bank Name * | Routing Number * | Account Number * | Account Type *: Select

SECTION 1 - PROPOSED INSURED: PERSONAL INFORMATION

Full Legal Name (First, Middle, Last) * | Sex *: Select | Date of Birth (MM/DD/YYYY) * | Age

Social Security Number (SSN) * | Driver's License # * | DL State * | DL Expiration (MM/DD/YYYY) *

Phone Number * | Client's Own Mobile (for e-sign texts) * | Email Address *

Height (ft' in") * | Weight (lbs) * | Ideal / Usual Weight (lbs)

Has your weight changed in the last 12 months? *: Select

If Yes: Amount of Change (lbs, gained/lost) | Reason for Weight Change

Home Address * | City * | State * | ZIP *

☐ Mailing address is the same as home address

Mailing Address (if different) | City | State | ZIP

Marital Status *: Select | # of Dependents | # of Children Under 18 | Household Size

Are you a US Citizen or Permanent Resident? *: Select

Birthplace (Country) * | Birth State * | If in US, City | Country of Citizenship (if not US)

** If NOT a US Citizen/Permanent Resident, please provide a copy of Visa. Birth State: enter N/A if born outside the US.*

Are you currently serving in the military, or do you plan to join? * Select

If Yes: Branch | Status / Details (active, reserve, planned entry date)

Primary Language | Translator Needed? Select | If Yes: Translator Name / Language

SECTION 2 - EMPLOYMENT & FINANCIAL INFORMATION

Employment Status * Select | Employer Name | How Long? | Industry

Employer Address | City / State | Job Title

Job Duties (describe main tasks)

Personal Annual Income (12 mo.) * | Household Income * | Net Worth * | Liquid Net Worth | Discretionary Income (Monthly)

Is the Proposed Insured the OWNER of this policy? * Select

If No - complete Section 12 (Other Payor / Owner).

Is the Proposed Insured the PAYER of this policy? * Select

If No - complete Section 12 (Other Payor / Owner).

SECTION 3 - EXISTING INSURANCE & POLICY HISTORY

Have you ever applied for life, health, or disability insurance that was declined, postponed, rated, or modified in any way? * Select

If Yes: Carrier | Date (MM/YYYY) | Reason

Please explain

Within the past 12 months, have you applied for or do you have any applications pending for life or disability insurance? * Select

If Yes: Carrier | Date Applied (MM/YYYY) | Submitted? Select

Please explain

Have you ever been offered any cash incentive or other consideration as an inducement to apply for or become an insured under this policy? * Select

If Yes: Please explain

Have you been involved in any discussions about the possible sale or transfer of this policy to an unrelated third party (e.g., life settlement company or investor group)? * Select

If Yes: Please explain

Existing Policies In Force

List up to 2 policies currently in force.

Policy 1: Insurance Company	Month/Year Issued	Amount ($)	Policy #	Policy Type
				Select

Policy 1: Are we replacing this existing policy? Select

If Yes:

1035 Exchange?	1035 Transfer Amount ($)	Full or Partial	Outstanding Loan?	Qualified Plan?
Select		Select	Select	Select

Reason for Replacement

Policy 2: Insurance Company	Month/Year Issued	Amount ($)	Policy #	Policy Type
				Select

Policy 2: Are we replacing this existing policy? Select

If Yes:

1035 Exchange?	1035 Transfer Amount ($)	Full or Partial	Outstanding Loan?	Qualified Plan?
Select		Select	Select	Select

Reason for Replacement

SECTION 4 - BENEFICIARY INFORMATION

Total share % must equal 100% for Primary beneficiaries, and separately 100% for Contingent beneficiaries.

Primary Beneficiaries

	Full Name *	Relationship *	Share % *	Date of Birth	SSN	Phone	Revocable / Irrevocable
1.							Select
2.							Select
3.							Select
4.							Select

Primary Total % (must equal 100)

Primary Beneficiary Notes

Contingent Beneficiaries

	Full Name	Relationship	Share %	Date of Birth	SSN	Phone	Revocable / Irrevocable
1.							Select
2.							Select

Contingent Total % (must equal 100)

Contingent Beneficiary Notes

Is any beneficiary a charity, trust, or estate? * Select

If Yes: Type: Select | Name of Charity / Trust / Estate | Trust Date / Tax ID / Trustee

SECTION 5 - CHILDREN'S TERM RIDER (CTR)

Children's Term Rider (CTR)? Select | Amount of Coverage ($) | CTR Notes

If YES, provide details for each child below:

	Date of Birth	SSN	Sex	Height	Weight
Child 1 Name			Select		
Child 2 Name			Select		
Child 3 Name			Select		
Child 4 Name			Select		

SECTION 6 - MEDICAL INFORMATION (MUST BE COMPLETED IN FULL)

Does the client have Health Insurance? Select

Primary Care Physician

Doctor's Name / Office * | Phone * | Last Visit Date *

Address * | City * | State * | ZIP *

Reason for Last Visit * Select | Results / Notes

Do you have any pending appointments with any health care provider or medical facility? * Select

If Yes: Appointment Date | Provider | Reason | Routine Physical? Select

Within the past 5 years, have you consulted with a specialist or had x-rays, EKGs, mammograms, ultrasounds, biopsy, or other medical tests/procedures (excluding HIV-related)? * Select

If Yes: Test / Specialist | Date | Reason | Results

Within the past 5 years, have you been admitted to a hospital, seen in an Emergency Department, or advised to enter a hospital for observation, operation, or treatment? * Select

If Yes: Facility | Date | Reason

Within the past 5 years, have you seen any other doctors or clinics (besides your primary care physician)? * Select

If Yes: Doctor / Clinic Name | Reason | Date

Prescription Medications (Past 12 Months)

Include OTC drugs or supplements only if taken for a chronic condition.

Medication 1 Name	Reason / Condition	Date Diagnosed	Daily Dosage	Prescribing Doctor
Medication 2 Name	Reason / Condition	Date Diagnosed	Daily Dosage	Prescribing Doctor
Medication 3 Name	Reason / Condition	Date Diagnosed	Daily Dosage	Prescribing Doctor
Medication 4 Name	Reason / Condition	Date Diagnosed	Daily Dosage	Prescribing Doctor

SECTION 7 - MEDICAL HISTORY (PAST 10 YEARS)

Answer YES or NO for each item. If YES, complete the "If Yes:" fields beside the question (condition, date diagnosed, treatment, medications, and treating doctor).

Any disorder of the HEART or CIRCULATORY SYSTEM - including irregular heartbeat, murmur, rheumatic fever, coronary artery disease, heart attack, chest pain, angina, high blood pressure, high cholesterol, aneurysm, TIA, stroke, or carotid artery disease? * Select

If Yes: Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications (Select) | Hospitalized for It? (Select) | Currently Treated? (Select) | Resolved? (Select) | Treating Doctor

**** AGENT: If YES for high blood pressure or high cholesterol, obtain most recent blood pressure reading, cholesterol panel (LDL/HDL/Total), and current medications.***

Latest BP Reading (e.g. 120/80) | BP Reading Date | Total Cholesterol | LDL | HDL

Current BP / Cholesterol Medications & Dosage

Any disorder of the LUNGS or RESPIRATORY SYSTEM - including sleep apnea, shortness of breath, asthma, bronchitis, emphysema, COPD, or tuberculosis? * Select

If Yes: Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications (Select) | Hospitalized for It? (Select) | Currently Treated? (Select) | Resolved? (Select) | Treating Doctor

Any DIGESTIVE SYSTEM disorder - including ulcer, hepatitis, cirrhosis, jaundice, or abnormality of the liver, stomach, intestines, pancreas, esophagus, gallbladder, or colon? * Select

If Yes: Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications (Select) | Hospitalized for It? (Select) | Currently Treated? (Select) | Resolved? (Select) | Treating Doctor

Any disorder of the BRAIN or NERVOUS SYSTEM - including seizures/epilepsy, tremors, fainting, migraines, memory loss, confusion, paralysis, numbness, or conditions limiting motion? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

Any disorder of the EYES, EARS, NOSE, THROAT, or SINUSES? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

Any ENDOCRINE disorder - including thyroid, pituitary, adrenal, or other gland conditions? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

DIABETES, high blood sugar, pre-diabetes, impaired fasting glucose, hyperglycemia, or gestational diabetes? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

**** AGENT: If YES, obtain most recent A1C level, fasting blood glucose reading, date of last lab work, and current diabetes medications/insulin dosage.***

Diabetes Type	Insulin?	Most Recent A1C	Fasting Glucose	Last Lab Date
Select	Select			

Current Diabetes Medications / Insulin Dosage

Any disorder of the MUSCULOSKELETAL SYSTEM - including spine, hip, knee, shoulder, back, joints, bones, muscles, arthritis, rheumatism, or gout? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

Any SKIN condition - including psoriasis, eczema, non-healing wounds, melanoma, or unusual moles/nevi? * Select

If Yes:

Condition / Diagnosis	Date Diagnosed	Treatment

# of Medications	Hospitalized for It?	Currently Treated?	Resolved?	Treating Doctor
Select	Select	Select	Select	

Any disorder of the URINARY SYSTEM - including bladder, kidney, or urinary abnormalities (protein, sugar, or blood in urine)? * Select

If Yes:

Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Select | Select | Select | Select

Any disorder of the GENITAL SYSTEM - including prostate, testicles, pelvic organs, ovaries, cervix, uterus, or breast? * Select

If Yes:

Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Select | Select | Select | Select

MENTAL HEALTH - including depression, anxiety, bipolar disorder, schizophrenia, ADD/ADHD, autism, Down Syndrome, Alzheimer's, dementia, or PTSD? * Select

If Yes:

Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Select | Select | Select | Select

Ever Attempted Suicide? | Work Missed (Past 12 Mo.)? | Seen Psychiatrist / Therapist / Other MD?

Select | Select | Select

Any BLOOD disorder - including anemia or hemophilia (excluding HIV/AIDS)? * Select

If Yes:

Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Select | Select | Select | Select

**** AGENT: If YES, obtain most recent CBC (complete blood count) results, hemoglobin/hematocrit levels, and any specialist notes.***

Most Recent CBC Results | CBC Date | Hemoglobin | Hematocrit

Specialist Notes

HIV, AIDS, or have you ever tested positive for exposure to HIV or AIDS? * Select

If Yes:

Condition / Diagnosis | Date Diagnosed | Treatment

# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Select | Select | Select | Select

Any CANCER, tumor, polyp, lump, nodule, cyst, lymphoma, or lymph node disorder? * Select

If Yes:
Condition / Diagnosis | Date Diagnosed | Treatment
# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

NEUROLOGICAL DISEASE - including Parkinson's, muscular dystrophy, Huntington's, ALS (Lou Gehrig's), or multiple sclerosis? * Select

If Yes:
Condition / Diagnosis | Date Diagnosed | Treatment
# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

AUTOIMMUNE DISORDER - including lupus, ataxia, transverse myelitis, myasthenia gravis, or post-polio syndrome? * Select

If Yes:
Condition / Diagnosis | Date Diagnosed | Treatment
# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

Amputation due to disease or other medical condition? * Select

If Yes:
Condition / Diagnosis | Date Diagnosed | Treatment
# of Medications | Hospitalized for It? | Currently Treated? | Resolved? | Treating Doctor

SECTION 8 - ASSISTIVE DEVICES & DAILY LIVING

Do you currently use or require any mechanical/medical devices such as a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator, oxygen, motorized cart, or stair lift? * Select

If Yes:
Please explain

Do you currently need help, assistance, or supervision for: bathing, eating, dressing, toileting, walking, transferring, or maintaining continence? * Select

If Yes:
Please explain

Do you currently need help, assistance, or supervision for: taking medication, doing housework, laundry, shopping, or meal preparation? * Select

If Yes:
Please explain

SECTION 9 - LIFESTYLE & BACKGROUND

Tobacco & Nicotine Use

Within the last 5 years, have you used any product containing tobacco or nicotine - including cigarettes, e-cigarettes, vape pens, cigars, pipes, chewing tobacco, snuff, nicotine gum, or nicotine patch? * Select

If Yes:

Last Date Used

Type of Product Select

How Much / How Often

Please explain

Substance & Alcohol Use

In the past 10 years, have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance; been advised by a physician to reduce alcohol or drug intake; used drugs not prescribed by a physician; been self-admitted to a drug/alcohol treatment facility; or been a member of a support group such as NA or AA? * Select

If Yes:

Please explain

On average, how many alcoholic drinks do you have per week? * Select

Driving & Legal History

During the last 5 years, have you pled guilty to or been convicted of any moving vehicle violations, DUI, or had a suspended license? * Select

If Yes:

Date(s)

Type of Violation (speeding, DUI, suspension, etc.)

Please explain

Within the past 10 years, have you been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation? * Select

If Yes:

Please explain

Financial & Disability

Within the past 5 years, have you worked less than full time, or received or applied for disability or worker's compensation? * Select

If Yes:

Please explain

Have you been or are you currently involved in any bankruptcy proceedings that have not been discharged? * Select

If Yes:

Please explain

Travel & Aviation

During the next 2 years, do you intend to live or travel outside of the United States for more than 2 weeks in a year? * Select

If Yes: Country / Countries | Duration | Purpose

Do you participate in any aviation activity other than as a fare-paying passenger? * Select

If Yes: Please explain

Hazardous Activities

Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, BASE jumping, bungee jumping, or cave exploration? * Select

If Yes: Please explain

SECTION 10 - FAMILY HISTORY

Biological parents and siblings only.

Father

Is your Father still living? * Select | Father's Current Age (or Age at Death) * | Cause of Death (if applicable)

Has your Father been diagnosed or treated for cancer, heart disease, Huntington's Disease, ALS, or polycystic kidney disease? * Select

If Yes: Condition(s) | Age at Diagnosis

Mother

Is your Mother still living? * Select | Mother's Current Age (or Age at Death) * | Cause of Death (if applicable)

Has your Mother been diagnosed or treated for cancer, heart disease, Huntington's Disease, ALS, or polycystic kidney disease? * Select

If Yes: Condition(s) | Age at Diagnosis

Siblings

Number of Siblings | Number Deceased | Sibling Notes

Has any biological sibling been diagnosed or treated for cancer, heart disease, Huntington's Disease, ALS, or polycystic kidney disease? * Select

If Yes: Condition(s) | Age at Diagnosis

If any sibling is deceased: Age at Death | Reason / Cause of Death

SECTION 11 - EMERGENCY CONTACTS

Please list 5 people we can contact to reach you about your policy.

Contact 1 *(required)*

Full Name * | **Relationship** | **Mobile Phone** *

Alternate Phone | **Email** | **City / State**

Contact 2 *(required)*

Full Name * | **Relationship** | **Mobile Phone** *

Alternate Phone | **Email** | **City / State**

Contact 3 *(required)*

Full Name * | **Relationship** | **Mobile Phone** *

Alternate Phone | **Email** | **City / State**

Contact 4

Full Name | **Relationship** | **Mobile Phone**

Alternate Phone | **Email** | **City / State**

Contact 5

Full Name | **Relationship** | **Mobile Phone**

Alternate Phone | **Email** | **City / State**

SECTION 12 - OTHER PAYOR / OWNER (COMPLETE IF INSURED IS NOT THE OWNER OR PAYER)

Full Legal Name

Sex
Select

Date of Birth

Age

Social Security Number (SSN)

Phone Number

Email Address

Home Address

City

State

ZIP

Employment Status
Select

Employer

Job Title

How Long?

Personal Annual Income

Household Income

Net Worth

Liquid Net Worth

Relationship to Insured

Role
Select

Notes

SECTION 13 - DECLARATIONS & CLIENT SIGNATURE

DECLARATION

I hereby give consent to my agent to E-Sign the application on my behalf. I also agree that all the information stated above is truthful and to the best of my knowledge. I understand that any misrepresentation may result in denial of claims or cancellation of coverage.

☐ I have read and agree to the declaration above.

Client Signature (type full legal name) *

Date (MM/DD/YYYY) *