Trial APPlication℠

Preliminary Inquiry—Not an application for life insurance.
This TAPP℠ form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact the underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Personal History — (this section must be completed)

Name ________________ Male ____ Female ____ Social Security # ________________

Address ________________ City ________________ State ________ Zip ________

Date of Birth ________ Age ______ Height ______ Weight ______ Monthly Income ________

Occupation ________________

Net Worth ________________

Agent Information — (this section must be completed)

Name ________________ Social Security # ________________ Phone Number ________________

Address ________________ City ________________ State ________ Zip ________

Email Address ________________

Requested Plan of Insurance — (this section must be completed)

Universal Life ____ Variable Life ____ Whole Life ____ Term, Level Period ________ Survivorship* ______ (*Please have other insured complete a TAPP)

Face Amount Desired ________________ Premium Amount Desired ________________ Annually ______ Monthly______

Insurance Companies Requested — Please Include your Agent ID/Rep Code for each Insurance Company requested

Insurance Company	Agent ID/Code

Please include a complete HIPPA authorization form.

If you are replacing coverage, will there be any 1035 money with this replacement Y / N If yes, what amount will be carried over?________________

What is the purpose of this insurance?________________

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?

All pages of the TAPP must be complete. Trial cannot be considered without an authorization form signed and initiated by Proposed Insured.

Trial APPlication

M. WILLIAMSON
INSURANCE SERVICES

Proposed Insured: ______________________ Social Security Number: ______________________

Medical History — (this section must be completed)

Who is your primary care physician? ______________________

Phone Number ______________________

Address ______________________ City ______________ State ________ Zip ________

____

When did you last consult him/her? Why? ______________________

____

____

____

What other physicians have you consulted during the past five years? Why? (Do not include insurance examinations)

Physicians Name ______________________ Phone Number ______________________

Address ______________________ City ______________ State ________ Zip ________

____

When did you last consult him/her? Why? ______________________

____

____

____

Physicians Name ______________________ Phone Number ______________________

Address ______________________ City ______________ State ________ Zip ________

____

When did you last consult him/her? Why? ______________________

____

____

____

Physicians Name ______________________ Phone Number ______________________

Address ______________________ City ______________ State ________ Zip ________

____

When did you last consult him/her? Why? ______________________

____

____

____

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Trial APPlication

M. WILLIAMSON
INSURANCE SERVICES

Proposed Insured: ______________________ Social Security Number: ______________________

Medical History — (this section must be completed)

In what hospitals, clinics, or other health facilities have you ever been treated?	Date	Illness
Please list all medications.		

Family History — (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Y / N
If yes, please provide the following details:

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

Hazardous Activities — ■ check here if this section is not applicable.

Are you a private pilot? Y / N if yes, provide details below.

How many total hours have you flown as Pilot in Command? ______________________

How many hours do you fly per year? ______________________

Do you have an IFR (instrument flight rating)? Y / N

Do you participate in the following activities? (circle those that apply)

Scuba Diving, Mountain Climbing, Bungee Jumping, Hang Gliding, Ultra light Flying, Auto/Motorcycle Racing, Sky Diving, Other

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Trial APPlication

M. WILLIAMSON
INSURANCE SERVICES

Proposed Insured: ______________________ Social Security Number: ______________________

Coronary — ■ check here if this section is not applicable.

Date of diagnosis of first chest pain: ______________________

Number of diseased vessels: ______________________

Dates/details of treatment/surgery (examples: Angioplasty, Bypass)

____

____

____

Date of last stress EKG: ______________________

Results: ______________________

By whom? ______________________

Any pain since treatment/surgery? ______________________

Cancer — ■ check here if this section is not applicable.

Exact name and location of cancer: ______________________

____

Stage and grade: ______________________

Who would have the pathology report? ______________________

____

Dates/details of treatment/surgery: ______________________

____

____

Diabetes — ■ check here if this section is not applicable.

Date of diagnosis: ______________________

Treatment: (circle one) Diet Only Oral Medication Insulin

Details: ______________________

Do you regularly test your blood glucose? Y / N Results: ______________________ Frequency: ______________________

Latest result of glycohemoglobin (A1C) test: __________ mg% Date: ______________________

Have you EVER had:

a. any eye trouble?	Y / N	d. kidney trouble?	Y / N
b. heart trouble?	Y / N	e. neuritis/neuralgia?	Y / N
c. high blood pressure?	Y / N	f. insulin reactions?	Y / N

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Trial APPlication

M. WILLIAMSON
INSURANCE SERVICES

Proposed Insured: ______________________ Social Security Number: ______________________

Drug and Alcohol Usage Questionnaire —

Do you currently drink alcohol? Y / N
Date of last consumption: ______________________
Note amount below.

Type:	Amount per week:
Beer	
Wine	
Liquor	

Did you ever drink substantially more than present? Y / N
If yes, when? ______________________
Note amount below.

Type:	Amount per week:
Beer	
Wine	
Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use? Y / N
Have you ever been arrested for driving under the influence of alcohol? Y / N
If yes, provide date(s): ______________________

Have you ever used illegal drugs or sought treatment because of drug use? Y / N
If yes, provide details: ______________________

Types of drug(s) used: ______________________

Date of last use: ______________________

Doctor/Facility name and address: ______________________

Tobacco/Nicotine Usage

Have you ever smoked cigarettes: Y / N If yes, date of last usage: ______________________

Have you ever used other tobacco or nicotine containing products: Y / N (examples: cigars, pipe, snuff, nicotine gum, or patch)

If yes, provide types and last date of use: ______________________

Notes:

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