

CUSTOMER DATA FORM

Customer Information

First & Last Name: _____ Male: _____ Female: _____

Address: _____ City: _____ State: _____ Zip code: _____ How long: _____

Phone # _____ Social Security # _____ Driver License # _____ State: _____

Place of Birth: _____ Date of Birth: _____ Height: _____ Weight: _____

Marital Status: _____ US Citizenship: Yes _____ No _____ / If "NO", Alien Registration # _____

Occupation: _____ Employer: _____ Month/Year Employed: _____

Net Worth: \$ _____ Household Income: \$ _____ Annual Income: \$ _____

Life Insurance Information

Current life insurance: Company _____ Type _____ Face Amt _____ Year _____

Requested Face Amt: \$ _____ APB \$ _____ Option A: _____ Option B: _____ Plan Name: _____

Draft Premium Payment on: 1st _____ 8th _____ 15th _____ 22nd _____ day each month

Health History

Family Doctor's Name: _____ Address: _____

Doctor's Phone # _____ Date Last Seen: _____ Reason: _____

Taking Medications (details): _____ Smoking: Yes ___ No ___

Health Condition's History last 10 years: _____

Family Health History: _____

Father: Age _____ State of Health _____ / OR Age at death _____ Cause of death _____

Mother: Age _____ State of Health _____ / OR Age at death _____ Cause of death _____

Brother/Sister: Age _____ State of Health _____ / OR Age at death _____ Cause of death _____

Beneficiary Information

Primary Beneficiary: _____ Relationship: _____ DOB: _____ SS#: _____

Primary Beneficiary: _____ Relationship: _____ DOB: _____ SS#: _____

Secondary Beneficiary: _____ Relationship: _____ DOB: _____ SS#: _____

Secondary Beneficiary: _____ Relationship: _____ DOB: _____ SS#: _____