LIFE INSURANCE FORM

Elite Insurance Associates – Email: Clesta@eiafl.com

Preferred Agent (Optional): _____

GENERAL INFORMATION

First Name: _____ MI: _____ Last Name: _____

Age: _____ DOB: _____ Gender: _____ Height: _____ Weight: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Primary: _____ Secondary: _____

E-mail Address: _____

***If answering "Yes" to any of the questions in this section, you may be requested to provide additional information at the time of application. ***

Do you smoke/ chew Tobacco? ☐ YES ☐ NO
Do you Vape? ☐ YES ☐ NO
Do you use any form of Marijuana? ☐ YES ☐ NO

If so, what type, how often, and is it prescribed?
_____
_____

Do you have any infractions on your Motor Vehicle Report? ☐ YES ☐ NO
Have you been Hospitalized within the past 10 years? ☐ YES ☐ NO
Do you have any felonies, misdemeanors, or Incarcerations? ☐ YES ☐ NO

Are you currently prescribed any medication by a member of a medical profession? If so, please list below. ☐ YES ☐ NO

Medication Name: _____
Condition: _____
_____

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Condition: _____
_____

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Condition: _____
_____

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Condition: _____
_____

COVERAGE INQUIRIES

What amount of coverage are you requesting? _____

Do you have a specific plan type you're interested in? For example, whole life or term life? _____

Do you have existing long-term care coverage? If so; how much? What type of plan? What company? Do you plan on replacing your current coverage? _____

_____