

Client Data Form

Data form does not capture any medical details or history for the Proposed Insured



1. PROPOSED INSURED'S INFORMATION

Insured's Name

DOB / / Gender F M SSN

License State | Number State of Residence

May not be required for all carriers but should be collected

At least one phone field is required.

Home Phone Number - - Mobile Phone Number - -

Work Phone Number - - Email

Primary Address City State Zip Code

Is the Proposed Insured a U.S. Citizen? Yes No Purpose of Insurance Personal Business

Will the insured own this policy? If no, completion Ownership Section. Yes No

2. PROPOSED COVERAGE *Additional Carrier or State specific questions may be asked on the drop ticket.*

Term Years Coverage Amounts \$

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Riders Accidental Death Benefit Waiver of Premium Child Term # of Units for Child Rider

Other Insurance

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No

Reason for replacement

Total accidental death insurance in force with all companies \$

Does the client have any existing or pending life insurance of annuities? *If Yes, please fill in the information below.* Yes No

Carrier	Amount	Policy Number	Issue Year	Replacement
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. POLICY OWNERSHIP

Owner's Name SSN/TIN

DOB or Trust Date / / Email Phone Number - -

Primary Address City State Zip Code

Relationship to Insured

4. BENEFICIARY INFORMATION The total should equal 100% per beneficiary type.

Name/Relationship	Primary/Contingent	Percent	DOB	SSN/TIN	<small>Optional from drop ticket submission but may be required before policy issue</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. TO BE COMPLETED BY AGENT

What is the source of funds for the initial premium?	<input type="text"/>	What is the source of funds for future premiums?	<input type="text"/>
How long have you known the Proposed Insured?	<input type="text"/>	Are you related to the Proposed Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you see the proposed insured at point-of-sale?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the proposed insured an active-duty service member of the US Armed Forces (including National Guard and Reserve)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Proposed Insured using income from their spouse/domestic partner to justify the coverage applied?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the policy owner or the person to whom this policy was sold an active-duty service member of the US Armed Forces (including National Guard and Reserve)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, what is the spouse/domestic partner's annual income?	\$ <input type="text"/>	If Yes, how much life insurance does the spouse/domestic partner have in force?	\$ <input type="text"/>
Do the proposed insured and owner read and understand the English language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Proposed Insured Annual Income / Net Worth <small>Required for John Hancock only</small>	\$ <input type="text"/> \$ <input type="text"/>