

LIFE & DISABILITY INSURANCE WORKSHEET

This is a fillable form. If you fill it out electronically - save the file and return it by email.
If you print it out and fill it out manually - scan it and return it by email or fax to 503-467-5567

First Name	M.I.	Last Name	Gender	Birth Date

Birth Place (city & state)	Social Security #	Drivers License #	Marital Status	Occupation & Duties

Earned Income (salary, bonus & share of business profit)	Other Income (rent, dividends, capital gains etc.)	Net Worth Including Business Value	Personal Liabilities

Home Address	City	State	Zip	Years At Address	Home Phone
Business Name & Address	City	State	Zip	Years w/employer	Business Phone

EXISTING LIFE INSURANCE POLICIES

Company	Policy #	Issue Year	Beneficiary	Death Benefit	Replace?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

EXISTING DISABILITY INSURANCE POLICIES

Types: I = Individual G = Group A = Association

Company	Policy #	Issue Yr.	Type I,G,A	Monthly Benefit	Benefit Period	Waiting Period	Does employer pay premiums?	Replace?
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. List your exact duties: _____

2. What percentage of your duties include physical activity such lifting, climbing, crouching, etc? ____%

3. How long have you been employed at your current job? _____ Years
If less than 2 years, list previous occupation & duration: _____

4. Do you plan to change your occupation? Yes No

5. Have you been actively at work on a full-time basis (minimum 30 hours per week) for the past 90 days (disregard vacation & normal non-working days)? Yes No

6. Have you been homebound or hospitalized due to injury or sickness in the past 90 days? Yes No

7. How many days have you missed due to injury or sickness in the past 90 days? _____

8. Are you currently disabled and/or collecting benefits? Yes No

9. Do you intend to travel outside of the U.S. or Canada in the next 2 years? Yes No
If yes, please provide destination, departure date & return date: _____

10. In the past 3 years, have you taken part in any avocation such as parachute jumping, hang gliding, skin or scuba diving? Is such activity planned? Yes No

11. In the past 3 years, have you been in a motor vehicle accident, charged with a moving violation of any motor vehicle law, or has your drivers license ever been suspended? Yes No

12. Is any application or reinstatement for disability, accident or health insurance pending? Yes No

13. Will your employer continue your salary or income if you become disabled? Yes No
If yes, amount per month: _____ for _____ months

14. What is your employment status?

Business Owner

OR Employee (no ownership)

Annual salary & Bonus: \$ _____

Annual Salary & Bonus: \$ _____

Annual business profit: \$ _____

Ownership percentage: _____%

Number of full-time employees: _____ Yr Established: _____

Sole Proprietor S-Corporation C-Corporation

Partnership – How many partners? _____

LLC – How many members? _____

15. Please complete this section if you work from your home.

a. Number of years with current business: _____

b. If less than 2 years, please describe your experience in this field:

c. Number of hours worked weekly: _____

d. Percentage of time spent working from home vs. at client's site: _____

e. Frequency of outside contact with clients: _____

f. Are clients seen in residence? _____

g. Do you have any contracts in force? _____

h. Are contracts short or long term?

16. Have you ever received treatment for or been diagnosed as having or had any of the following (if Yes, check condition and provide details in comments section)? Yes No

- | | | |
|----------------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychological Disorder |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Rheumatologic Disorder | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Physical Impairment | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Seizure | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prostate Disorders |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> High Cholesterol | |

17. Have you ever had any disorder of the following? Yes No
(if Yes, check condition and provide details in comments section)?

- | | | |
|----------------------------------------|----------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Blood | <input type="checkbox"/> Bones | <input type="checkbox"/> Gastrointestinal System |
| <input type="checkbox"/> Lymph Nodes | <input type="checkbox"/> Joints | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Blood Vessels | <input type="checkbox"/> Eyes | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Ears | <input type="checkbox"/> Genitourinary System |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Heart | <input type="checkbox"/> Immune System |
| <input type="checkbox"/> Back | <input type="checkbox"/> Lungs | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Breasts | |

18. Height: _____ Weight: _____
19. Latest cholesterol readings (if known) Total: _____ LDL: _____ HDL: _____
20. Latest blood pressure reading (if known): _____ / _____
21. Have you ever smoked cigarettes or used other nicotine products? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, type of nicotine: _____ Date of last use? _____
22. Have you applied for insurance in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Have you ever been declined or rated for insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
24. Have you ever filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No
26. Have you ever requested or received a pension, benefits or payments because of an injury, sickness or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Have you ever received treatment in relation to alcoholism, use of alcohol or controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No
28. Have you ever used barbiturates, narcotics, cocaine or other controlled substance not prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
29. Do you fly airplanes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Instrument rated: <input type="checkbox"/> Yes <input type="checkbox"/> No # of total solo hours: _____ Avg annual solo hours: _____
30. Do you regularly exercise 3 or more times per week? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what types of exercise: _____

31. Please list all medications currently prescribed.

Prescription	Dosage	Frequency	Reason

32. Please list the following information regarding your personal physician, specialists & hospital visits:

Name	Address & Phone Number	Date Last Seen	Reason & Treatment

33. Other than above, within the **past 5 years** have you had any illness, infection, injury, surgery, physical exam, medical consultation, counseling, electrocardiogram, x-ray or laboratory study, or been a patient in a hospital or other medical facility (if yes please provide details in comments section) Yes No

34. Family medical history:

	Age If Living	Age at Death	Heart Disease History?	Cancer History?
Father	_____	___ cause _____	<input type="checkbox"/> No <input type="checkbox"/> Yes age onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes age onset ___ Type_____
Mother	_____	___ cause _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes age onset ___ Type_____
Sibling	_____	___ cause _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes age onset ___ Type_____
Sibling	_____	___ cause _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes age onset ___ Type_____

Please provide details regarding any “Yes” answers and applicable medical conditions:
