



Person To Be Insured Information

Please correct the fields indicated below before continuing.

First Name:	James	Last Name:	Spahr
 Date of Birth: (mm/dd/yyyy)	<input type="text" value="01/16/1974"/>	 Gender:	<input checked="" type="radio"/> Male <input type="radio"/> Female
Marital status?	<input type="text" value="Single"/>	Relationship to James?	Self
Height:	<input type="text" value="6"/> <input type="text" value="2"/>	Weight:	<input type="text" value="210"/> pounds
Has this person used any tobacco products in the past 12 months?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Is this person an expectant mother or father?	<input type="radio"/> Yes <input checked="" type="radio"/> No

Check any of the following that the person to be quoted has been diagnosed with (in the past 10 years):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Alcohol/ Drug Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pulmonary Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |

If you've checked any of the above, please provide date of onset, diagnosis, and current status:

Does this person take any medications?

☒ Yes ☐ No

If you answered Yes to medications, please list medication name and dosage:

Does this person have any immediate relatives who have ever had heart disease?

☐ Yes ☒ No

Does this person have any immediate relatives who have had any form of cancer?

☒ Yes ☐ No

Has this person been a U.S. or Canadian resident for at least 12 months?

☒ Yes ☐ No

What is this person's highest education level?

Past or Present Military experience?

Select occupation that most resembles this person's profession and approximate number of years in this occupation?

for year(s)

OK, Save This Information