

CUSTOMER DATA FORM

Full Name: _____ Martial Status: _____ M: _____ F: _____

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

Years At Residence: _____ Phone #: _____ SS #: _____

DL #: _____ Expiration: _____ Birth City/State: _____

Date of Birth: _____ Height: _____ Weight: _____

US Citizenship: Y/N: _____ Alien Registration #: _____ Email: _____

Occupation: _____ Employer: _____ Years Employed: _____

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

Bank Name: _____ AC#: _____ RT#: _____

Do you currently have a life insurance policy? _____

Doctor's Name: _____ Address: _____

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

Medications Y/N: _____ Prescriptions/Dosage/diagnosis date: _____

Smoke: Y/N: _____

Any Health Issues last 10 years: Y/N: _____ List: _____

Any Family Health History: _____

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

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

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

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

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

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

Premium