UNDERWRITING APPRAISAL & PRELIMINARY INQUIRY FOR INSURANCE

Advisors Financial Group, Inc. (AFG) and Insurance Designers of America, LLC (IDA) offer a preliminary underwriting process to assist advisors and their clients. This information will be used to obtain informal insurance policy pricing and to select the insurance companies for submission of a formal application. This form is not an application for insurance or any other financial product. Please complete one form for each client.

Agent or Financial Advisor Name

Personal Information						
Full Name				Gender	Marital Status	Date of Birth
				M F		
Street Address				City	State	Zip Code
Height	Weight	Social Security Number	Driver License Number	DL State	Cell Phone	Email Address
Are a US Citizen?	Yes	No	If no, list country of citizenship			
Green Card?	Yes	No	Type of Visa			
Occupation				Employer		
Earned Income		Unearned Income		Other Income		Net Worth
Purpose of Insurance (Income Replacement, Family Needs, Buy/Sell, Key Person, Estate Planning, Executive Benefits, etc.)						
Proposed Plan or Type of Insurance			Benefit Amount	Are you considering Replacement of an existing policy?		
				Yes	No	

Personal History		
Have you or do you: (***Please provide full details for any "yes" answers)***	Yes	No
1) Used tobacco or nicotine of any kind, including e-cigarettes, over the last 5 years? *(If yes, provide type, amount)*		
2) Flown as a pilot, student pilot or crew member, or intend to fly as such? *(If yes, complete an Aviation Questionnaire)*		
3) In the past five years engaged in racing, scuba diving, mountain climbing, sky diving or other hazardous activity that might impact your insurance rate class?		
4) Have you traveled outside the US in the past 24 months or is such travel planned in the next 24 months? *(If yes, list the countries and dates visited and/or the countries and dates you plan to visit)*		

Personal History *(Continued)*		
Have you or do you: (***Please provide full details for any "yes" answers)***	Yes	No
5) Had any motor vehicle accidents, DWIs, speeding tickets, or other traffic violations in the past seven years or has your driver's license ever been suspended or revoked?		
6) Ever been convicted of, or pled guilty or no contest to a felony or have any such charges pending?		
7) Consulted a physician or had treatment for the use or possession of alcohol, narcotics, stimulants, sedatives, hallucinogenic drugs, or other medications?		
8) Had a parent or sibling who was diagnosed with and/or died from cancer, diabetes, stroke, heart, or kidney disease, or who committed suicide? *(If yes, show age of onset and/or age death occurred in Remarks)*		
9) Ever applied for insurance and had the policy rated, postponed, or declined?		
10) Do you have any other pending life insurance at this time? *(If yes, death benefit? Type of coverage?)*		
11) Have you declared bankruptcy in the last 5 years? *(If yes, what chapter? When filed? When dismissed?)*		

Medical History		
12) Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following: (***Please provide full details for any "yes" answers including Dates, Diagnosis, Medication or Treatment Prescribed, and list the Medical Professional or Facility seen)***	Yes	No
a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache)?		
b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain)?		
c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis)?		
d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs?		

Medical History *(Continued)*		
Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following: (***Please provide full details for any "yes" answers including Dates, Diagnosis, Medication or Treatment Prescribed, and list the Medical Professional or Facility seen)***	Yes	No
e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation)?		
f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles)?		
g) Any disorder or disease of eyes, ears, nose, or throat?		
h) Any disorder or disease of the blood, skin, thyroid, lymph, or other glands (such as anemia, diabetes)?		
i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, or Obsessive-compulsive)?		
j) Any cancer, tumor, cyst, or nodule?		
k) Any sexually transmitted disorders or diseases?		
l) Any disorders or diseases of the immune system (HIV or AIDS)?		
13) Within the past five (5) years, have you: (***Please provide full details for any "yes" answers)***	Yes	No
a) Been treated, examined, or advised by a member of the medical profession for any condition other than stated in the previous section?		
b) Been advised by a member of the medical profession to get specified medical care, hospitalization, surgery, or diagnostic test, which has not been completed?		
c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity?		

Medical History (Continued)		
Within the past five (5) years, have you: (***Please provide full details for any "yes" answers)***	Yes	No
d) Had any diagnostics test, electrocardiogram (EKG), MRI, CT-Scan or X-ray?		
e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet?		
f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home?		
g) Made a claim for or received benefits, compensation or pension for any injury, sickness, disability, or impaired condition?		

14) When was your last Doctor's visit with full physical?	Month		Year	

Physicians and Medical Facilities Consulted for Health Care or Periodic Check-Ups			
Name	Address	Phone	Date and Reason Seen