Guardian

Individual Life and Disability Insurance Underwriting Inquiry

This is a preliminary inquiry, not an application for insurance.

Proposed Insured Information

1. First Name _____ MI _____ Last Name _____

2. Street Address (Primary Residence) _____

City _____ State _____ Zip _____

3. Date of Birth (mm/dd/yyyy) _____ **4.** Place of Birth _____

5. Social Security Number _____ **6.** Gender ☐ Male ☐ Female

7. Are you a U.S. Citizen? ☐ Yes ☐ No If "No," are you a permanent resident (green card holder)? ☐ Yes ☐ No

If "No": Country of Citizenship _____ ☐ Green Card ☐ Visa Exp. Date _____

8. Occupation _____

9. Height _____ ft _____ in **10.** Weight _____ lbs **11.** Weight loss/gain in last 12 months _____ lbs

12. Do you intend to travel outside of the U.S. within the next 2 years? (Where, How Long, Reason) ☐ Yes ☐ No

_____

_____

_____

13. Have you ever used tobacco in any form or any nicotine delivery system? ☐ Yes ☐ No

If "Yes": Type _____ Quantity _____ Date Last Used (mm/dd/yyyy) _____

Proposed Insurance Information

1. Amount and Plan of Life/Disability Insurance Proposed _____

2. Approximate Planned Premium $ _____

Current Insurance Information

1. Have you ever been offered a rated/modified policy or declined for insurance with any carrier? ☐ Yes ☐ No
If "Yes," please complete chart below.

Name of Company	Amount	Date	Rated
			☐ Rated/Modified ☐ Declined
			☐ Rated/Modified ☐ Declined
			☐ Rated/Modified ☐ Declined

2. Except as listed above, please list any in-force or pending Life/Disability insurance with all carriers (include Group).

Name of Company	Amount	Year Issued*	Replacement? (Y or N)
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

***If insurance has not been issued, indicate "Pending."**

3. Is there any formal or informal application pending with any other carrier? ☐ Yes ☐ No *If "Yes," give details and Company.*

_____

_____

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Physician Listing

Personal Physician _____

Address _____

Phone Number _____ Reason and Date Last Seen _____

Additional Physician Consulted _____

Address _____

Phone Number _____ Reason and Date Last Seen _____

Additional Physician Consulted _____

Address _____

Phone Number _____ Reason and Date Last Seen _____

Medications

Medication	Reason	How Long?	Date Last Used (mm/dd/yyyy)

Impairment Details (indicate N/A if not applicable)

Diabetes

Type of Diabetes: _____

Date of Diagnosis: _____

Treating Doctor: _____

Treatment: _____

Last Hemoglobin A1C with date: _____

Any Complications? _____

Heart Disease

Date of Diagnosis: _____ Heart Attack: ☐ Yes ☐ No

Results of Catherization (# of vessels, % of blockage): _____

Angioplasty (dates, which vessels, stent used, etc): _____

Bypass (dates & results): _____

Date & results of last stress testing: _____

Treating Doctor: _____

Cancer:

Date of Diagnosis: _____

Type of Cancer: _____ Stage & Grade: _____

Type of Treatment: _____

Date completed Treatment: _____

Treating Doctor: _____

Other

Condition: _____

Date of Diagnosis: _____

Treatment: _____

Dates of Treatment: _____

Tests/Procedures: _____

Treating Doctor: _____

Date Last Seen: _____

Drug & Alcohol History

Dates of Treatment: _____

Attending AA? _____

Any recurrence? (Include all dates): _____

Any DUI or arrests? (Include all dates): _____

Family History

Family Member	Age if Living	Medical History	Age at Death	Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				

Additional Information

_____

_____

STOP!

If this is a medical only inquiry, please skip to the Acknowledgement and Signature section on page 5.

Personal Financial Information *(Complete **only** if the inquiry is for personal coverage.)*

1. Is purchase of an insurance policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

2. Do you believe you have the financial ability to make premium payments on an insurance policy? ☐ Yes ☐ No

3. Have you ever filed for personal or business bankruptcy? ☐ Yes ☐ No

If "Yes": ☐ Personal ☐ Business Date of Discharge (mm/dd/yyyy): _____

If bankruptcy has not been discharged, please provide the chapter/type of bankruptcy and the date it filed in the Remarks section.

4. Personal Finances:

Personal Finances	Proposed Insured	Owner (if other than Insured)
Actual Income (Year to Date This Calendar Year)	$	$
Actual Income (Last Calendar Year)	$	$
Actual Income (Two Calendar Years Ago)	$	$
Actual Unearned Income (Last Calendar Year)	$	$
Net Worth	$	$
Expected Earned Income (This Year)	$	$
Expected Unearned Income (This Year)	$	$

Business Finances *(Complete **only** if the inquiry is for business coverage.)*

5. Type of Business (Check One): ☐ Limited Liability Co. ☐ Sole Proprietor ☐ Partnership ☐ S Corp ☐ C Corp ☐ Other _____

6.

Total Business Assets	$
Total Business Liabilities	$
Business Net Worth	$
Total Business Expenses Prior Year	$
Total Business Expenses Prior 2 Years	$
Total Gross Receipts Prior Year	$
Total Gross Receipts Prior 2 Years	$
Business Net Profit After Taxes for Prior Year	$
Business Net Profit After Taxes for 2 Years Prior	$

7. How long has the business been established: ☐ Less than 1 year ☐ 1-5 years ☐ Greater than 5 years

8. What is the nature of the business? _____

9. What percentage of the business is owned by the Proposed Insured? _____ %

10. Is there business insurance applied for or in force on other key members of this firm? ☐ Yes ☐ No

If "Yes", please provide details: _____

Acknowledgment and Signature

I acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice and Medical Records.

Signed at _____ _____

City and State | Month/Day/Year

_____

Signature of Proposed Insured
(*or parent or guardian if insured is under 18*)

_____ _____

Soliciting Agent's Name | Agent No.