CONFIDENTIAL TRIAL APPLICATION

RETURN TO:	AGENT NAME: ADDRESS: E-MAIL: PHONE:

FULL NAME	DATE OF BIRTH	AGE
RESIDENT ADDRESS (STREET & NUMBER)	PLACE OF BIRTH (STREET & NUMBER)	
CITY, STATE & ZIP / HOW LONG?	OCCUPATION	
AMOUNT OF INSURANCE	COVERAGE (TERM, UL, VUL, WL)	BENEFICIARY (NAME & RELATIONSHIP)
HEIGHT / WEIGHT	YOUR MOTHER'S AGE (IF DECEASED, AGE AT DEATH): ☐ LIVING ☐ DECEASED—CAUSE?	YOUR FATHER'S AGE (IF DECEASED, AGE AT DEATH): ☐ LIVING ☐ DECEASED—CAUSE?

MEDICAL BACKGROUND AND HISTORY

NAME & ADDRESS OF YOUR PERSONAL PHYSICIAN	DATE AND REASON LAST CONSULTED
CITY, STATE & ZIP	WHAT ADVICE OR TREATMENT WAS PRESCRIBED?

	YES	NO
A. Have you ever been treated for or had any:		
1. Disorders of the eyes, ears, nose or throat?	☐	☐
2. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?	☐	☐
3. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☐
4. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	☐	☐
5. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion, or other disorder of the stomach, intestine, liver or gall bladder?	☐	☐
6. Sugar, albumin, blood or pus in urine, venereal disease, nephritis, stone, or other disorder of the kidney, bladder, prostate or reproductive organs?	☐	☐
7. Diabetes, thyroid, or other endocrine disorder?	☐	☐
8. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones?	☐	☐
9. Deformity, lameness, or amputation?	☐	☐
10. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐
11. Allergies, anemia or other disorder of the blood?	☐	☐
B. In the past 10 years have you:		
1. Been told you have tested positive for antibodies of, received treatment or advice for acquired immune deficiency syndrome, AIDS related complex, or AIDS related conditions?	☐	☐
2. Used barbiturates, amphetamines, hallucinogenic drugs (including marijuana), narcotics, or any prescription drug except as prescribed by a physician?	☐	☐
3. Ever received counseling, advice or treatment regarding the use of alcohol or drugs? (See questionnaire on Page 2)	☐	☐
C. Are you now under observation by a physician for any disorder, or taking treatment for any disorder?	☐	☐
D. Have you smoked cigarettes in the past 12 months?	☐	☐
E. Do you use any other nicotine products?	☐	☐
F. Have you had life or health insurance declined, modified, rated, or its renewal refused?	☐	☐

Please furnish complete details of any "YES" answers: _____

_____

_____

Please complete all applicable questions on both pages and have the proposed insured sign the Authorization.

CONFIDENTIAL TRIAL APPLICATION

Consideration requires completion of both pages including signature of the proposed insured

SUPPLEMENTAL IMPAIRMENT QUESTIONS

FULL NAME	DATE OF FIRST DIAGNOSIS OF: CHEST PAIN? DIABETES? CANCER?
NAME AND ADDRESS OF SPECIALIST FIRST CONSULTED	CITY, STATE & ZIP

CORONARY QUESTIONS

Have you ever had or been treated for:	**YES**	**NO**
Chest pain? (Angina pectoris)	☐	☐
Heart attack? (Infarction)	☐	☐

How often do you get heart symptoms (pressure, pain or discomfort)?
Number times/month? _____
Number times/year? _____
Date of MOST RECENT treadmill (stress) EKG? _____

Have you had or ever been advised to have:		
Cardiac catherization?	☐	☐
Coronary angioplasty?	☐	☐
Coronary bypass surgery?	☐	☐

How long were you out of work due to any of the above? _____

Date of last:
Blood pressure check? _____
Results: _____
Cholesterol check? _____
Results: _____

Is there family history of stroke, diabetes or heart disease?	☐	☐

DIABETES QUESTIONS

What treatment do you use for your diabetes?	**YES**	**NO**
Diet only?	☐	☐
Oral tablets?	☐	☐
Insulin injection?	☐	☐

Type: _____
Daily Dose: _____

What type of self-testing do you do?		
Blood?	☐	☐
Urine?	☐	☐

Results:		
Usually negative?	☐	☐
Usually a trace?	☐	☐
Usually more than a trace?	☐	☐

Frequency: _____
Last result: _____ Avg.: _____
Last Hemoglobin A1C test readings:
Date: _____ Result: _____

Have you ever been treated for:		
Insulin reactions	☐	☐
Diabetic coma?	☐	☐
Eye trouble?	☐	☐
High blood pressure?	☐	☐
Kidney trouble (Albumin)?	☐	☐
Neuritis or neuralgia?	☐	☐
Arteriosclerosis?	☐	☐
Liver disorders?	☐	☐
Skin problems/infections?	☐	☐
Has weight changed in the last year?	☐	☐

Weight one year ago _____

CANCER QUESTIONS

Type of cancer? (give the full medical name, if known) _____

Stage, Level, or Grade? _____
Location of cancer? _____

Type of treatment given? _____

Date treatment started: _____
Most recent treatment: _____
Date of last follow-up _____

ALCOHOL & DRUG QUESTIONS

	YES	NO
Do you use alcohol or drugs at the present time?	☐	☐
Are you involved in AA, NA or any other support group?	☐	☐
Ever been arrested or convicted for any alcohol or drug violation?	☐	☐
Have you ever received treatment or counseling?	☐	☐

Please furnish complete details of any "YES" answers: _____

AVIATION QUESTIONAIRE

1. As a pilot or student pilot indicate:
   a) The number of hours flown in command:
   _____
   b) Date of last flight: _____
   c) Type of license currently held: ☐ Student ☐ Private ☐ Commercial ☐ Senior ☐ ATR
   d) Do you hold a valid instrument rating? ☐ Yes ☐ No

2. Number of hours flown in the last 12 months: _____ HOURS
   AND last 12-24 months: _____ HOURS

3. Number of flying hours contemplated in the next 12 months: _____HOURS

4. Purpose of present and future flying: ☐ Pleasure ☐ Commercial ☐ Military ☐ Personal ☐ Business ☐ Other
   If other, please specify: _____

5. Indicate category, class, and type of aircraft flown: _____

6. Do you engage or expect to engage in Student Instruction, Charter Flying, Freight Carrying, Sight Seeing, Photography, Crop Dusting, Prospecting, Test or Inspection Flying? ☐ Yes ☐ No Which?
   _____

7. If aviation requires an extra premium or exclusion rider, which would you prefer? ☐ Extra Premium ☐ Exclusion Rider

SCUBA DIVING QUESTIONAIRE

1. Do you dive for pleasure? ☐ Yes ☐ No OR commercial purposes? ☐ Yes ☐ No
   If yes, details:
   _____

2. Do you engage in: ☐ Ice Diving? ☐ Cave or Night Diving? ☐ Search/Rescue Work? ☐ Salvage?

3. What are the locations of you diving activities? ☐ Lakes ☐ Rivers ☐ Pools ☐ Ocean ☐ Deep Sea ☐ Other
If other, please clarify:
_____

4. Diving History:

	Last 12 Months		Next 12 Months	
	# of Dives	Average Time	# of Dives	Average Time
< 50 Feet				
50 - 75 Feet				
76 - 100 Feet				
101 - 150 Feet				
151 Feet & Over				

5. Do you dive alone? ☐ Yes ☐ No If yes, how often? _____

6. Are you a certified diver? ☐ Yes ☐ No A member of an organized club? ☐ Yes ☐ No
   If yes, give details:_____
   _____
   _____
   _____

RACING QUESTIONAIRE

1. Type of Racing: ☐ Automobile ☐ Motorcycle ☐ Snowmobile ☐ Boat
   Make and Model of vehicle used in races:_____

2. How many races did you enter in the past 12 months?_____ 12-24 Months? _____
   Contemplate entering in the next 12 months?_____

3. What is the maximum speed attained? _____ Average Speed? _____

4. What types of racing or competition do you engage in? _____
   (EXAMPLE: Automobile – Midge, Sports Car, Stock Car, Championship, Drag, Sprint, Etc. Motorcycle – Hill Climbing, Cross Country, Drag, Track, Etc.)

5. Class _____ ☐ IMSA ☐ SCCA

6. Purpose of Racing: ☐ Professional ☐ Amateur ☐ Both (DETAILS) _____

FOREIGN TRAVEL & RESIDENCE QUESTIONAIRE

1. Country of Birth: _____

2. Date of Entry to USA: _____

3. Country of Citizenship (IF US CITIZEN SKIP TO #5): _____

4. a) Visa Type: _____ b) Symbol: _____
   c) Number: _____ d) Expiration Date: _____

5. a) Have you traveled or resided outside of the US in the past 24 months? ☐ Yes ☐ No
   b) Do you plan to in the next 12 months? ☐ Yes ☐ No

   DETAILS:

	DESTINATION	DATES	DURATION OF STAY
12-24 Months			
Past 12 Months			
Next 12 Months			

6. What kind of accommodations do you stay in while outside of the USA?
   ☐ Hotel ☐ Hostel ☐ Privately Owned Home ☐ Family ☐ RV Park ☐ Camping ☐ Other
   If other, please explain:_____

7. What mode of transportation do you use while outside of the USA?
   ☐ Own Car ☐ Rent Car ☐ Train/Subway ☐ Boat/Ferry ☐ Airplane ☐ Other
   If other, please explain:_____