FINANCIAL STRATEGIES GROUP, LLP

FSG Application Ticket

Section 1 – Insured Information

First Name	Middle Name	Last Name	
Are you a U.S. citizen? ☐ Yes ☐ No	SSN or TIN	Date of Birth	Birth State
Driver's License Number	License State	Expiration Date	
Street Address, City, State Zip Code		Gender ☐ Male ☐ Female	
Marital Status	Phone Number	Email	
Employer & Occupation	Work Number	Number of years at employer	
Work Street Address, Suite # City, State, Zip			

Section 2 – Basic Health Information

Complete only if the Quick Quote Questionnaire is not included

Height	Weight	Do you use any form of tobacco?	☐ Yes, type and how often ☐ No
Is your mother living?	☐ Yes ☐ No, please provide age and cause of death		
Is your father living?	☐ Yes ☐ No, please provide age and cause of death		

Section 3 – Inforce Information

***if more than one policy is inforce, please request the Additional Inforce Information Page**

Carrier	Death Benefit	Policy Number
Issue Date	Current Premiums	1035 Funds
Reason For Replacement, if applicable		

Ok to send documents via Docusign? ☐ Yes ☐ No

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Section 4 – Owner Information

Complete only if the owner is other than the insured

Name of Individual, Trust, or Business	**Date of Birth or Trust Date**	**SSN or Tax ID**
Gender ☐ **Male** ☐ **Female** ☐ **N/A**	**Email**	**Relationship to Insured**
Street Address, Apt # City, State, Zip		
Name of Trustee(s) or Officer(s)		
Trustee(s) or Officer(s) email address(es)		

Section 5 – Beneficiary Information

Complete only if owner is not a business or trust

Name	**Date of Birth**	**SSN**	**Relationship to Insured**
Gender ☐ **Male** ☐ **Female**	**Phone number**	**Email**	
Street Address, Apt # City, State, Zip			

Section 6 – Financial Information

Assets	**Liquid Assets**	**Liabilities**
Unearned Income	**Earned Income**	**Spouse's Income**
Unearned Income and Source(s)		

Section 7 – Agent Information

Agent Name	**SSN**	**How long have you known the agent?**
***Account #**	***FA Rep Code**	

*If applicable

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Section 8 – Travel Information

Any Booked Travel Planned Outside of the USA ☐ Yes ☐ No	☐ Business ☐ Pleasure
Dates and Duration	**City(ies)**

Section 9 – Miscellaneous Information

Example: Additional medical history not mentioned on Quick Quote; additional individual/business financial information; other pending life insurance applications; etc.

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Section 10 – Physician(s) Information

Please provide a list of all the medical doctors and hospitals you have been to in the past 5 years

Name	Phone Number	Online Portal Access?	☐ Yes ☐ No
Street Address, Ste # City, State, Zip			
Date of your last visit	Reason and outcome of visit		
Name	Phone Number	Online Portal Access?	☐ Yes ☐ No
Street Address, Ste # City, State, Zip			
Date of your last visit	Reason and outcome of visit		
Name	Phone Number	Online Portal Access?	☐ Yes ☐ No
Street Address, Ste # City, State, Zip			
Date of your last visit	Reason and outcome of visit		
Name	Phone Number	Online Portal Access?	☐ Yes ☐ No
Street Address, Ste # City, State, Zip			
Date of your last visit	Reason and outcome of visit		

Please make sure to list all doctors seen. If there are missing doctors, this can delay the process by 4-6 weeks as the underwriter needs your complete medical file. Ask for an additional page, if needed.

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FSG Medical History Quick Quote

Section A – Personal Information			
Client Name:	M ☐ F ☐	Date of Birth:	
Advisor Name:		Height:	
Firm:		Weight:	

Section B – Personal Health History (For "Yes" Answers, please provide details)			
In the last 10 years, have you been treated for, or diagnosed with:		Yes	No
1	High blood pressure, heart attack, chest pain, heart murmur, irregular heartbreak, stroke, or any other disease or disorder of the heart or blood vessels? Most recent blood pressure reading Cholesterol Ratio	☐	☐
2	Cancer, tumor, cyst or growth? Type Date(s) Stage/Grade	☐	☐
3	Asthma, bronchitis, emphysema, tuberculosis, or any other disease or disorder of the lungs or respiratory system?	☐	☐
4	Seizure, paralysis, headaches, multiple sclerosis, or any other disease or disorder of the brain or nervous system?	☐	☐
5	Chronic fatigue, stress, depression, anxiety, or any emotional or psychological disorder?	☐	☐
6	Hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas, or digestive tract?	☐	☐
7	Diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? Date of Diagnosis Current A1C Treatment	☐	☐
8	Kidney stones, nephritis, blood or protein in the urine, HIV, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system?	☐	☐
9	Any disease or disorder of the bones, joints, or muscles?	☐	☐
Section C – Family and Personal History			
10	Have your parents or siblings died from diabetes, cancer, stroke, or heart disease? Person/Age at death/Diagnosis	☐	☐
11	Are you **currently** taking any medications? Provide details (Give the name of drug, dosage, and reason for taking):	☐	☐
Section D - Activities and Health Habits Within the Last 5 Years..			
12	Have you used tobacco in any form (including gum/patch)? Type Date last used	☐	☐
13	Engaged in any of the following activities: scuba/skin diving, pilot, organized motor vehicle racing, skydiving, hang gliding, mountain climbing, or rodeo?	☐	☐
14	Any future foreign travel plans outside the U.S. or Canada? Provide details in space below.	☐	☐
15	Been in a motor vehicle accident, had a DUI or have more than two moving violations?	☐	☐
16	If answered **YES** to any question 1-15 above please provide details:		