

eApp client information questionnaire

FOR AGES 15+

Insured information

First name _____ Middle initial _____ Last name _____

DOB ____/____/____ Gender: Male Female

State of solicitation _____ County of residence _____

Birth country _____ Birth state (U.S.) _____

Citizenship _____ SSN/Tax ID _____ - _____ - _____

Is the proposed insured in the armed forces, National Guard or reserves? Yes No

(If yes, complete the Foreign Residence and Travel Questionnaire form.)

Driver's license number _____ Issue state _____ Expiration _____

Earned income \$ _____ Total net worth \$ _____

Unearned income \$ _____ Liquid net worth \$ _____

Are you employed? Yes NoAre you self-employed? Yes No

Occupation _____ Years in occupation _____

Contact information

Cell phone _____ Home phone _____

Street address _____ City _____ State _____ Zip _____

County _____ Email _____

Health and lifestyle

Current height _____ ft _____ in Current weight _____

Have you ever used tobacco or nicotine products in any form
(including cigarettes, cigars, chewing tobacco, pipe, e-cigarette /vape, nicotine patch or gum)? Yes No

If yes, answer the following: Tobacco type: _____ Date of last use: _____

Number of uses in the last year: _____

Have you been diagnosed or treated for any of the following: Yes No

- Alcohol/drug abuse and/or treatment
- Heart disease
- Stroke/transient ischemic attack
- Atrial fibrillation
- Emphysema/chronic obstructive pulmonary disease
- Hepatitis or cirrhosis
- Inflammatory bowel disease (Crohn's disease, ulcerative colitis)
- Kidney disease
- Diabetes
- Cancer, except for basal cell carcinomas
- Bipolar disorder
- Seizure disorder
- Parkinson's disease
- HIV/AIDS
- Schizophrenia
- Lupus
- Rheumatoid arthritis
- Multiple sclerosis

Do you plan to travel or reside outside of the U.S. in the next two years? Yes No
(If yes, complete the Foreign Residence and Travel Questionnaire)

Do you intend on traveling to a hazardous location? Yes No

Do you have a history of misdemeanor or felony? Yes No
If yes, was it within last 5 years? Yes No

Do you have a history of DUI in the last year, or history of
DUI and any other moving violations in the last five years? Yes No

Have you applied for life insurance in the last six months? Yes No
Have you ever been rated or declined for life or disability insurance? Yes No

Have you applied for life insurance in the past five years that was declined or rated? Yes No
If yes, provide details _____

Have you completed labs for life or disability insurance in the last 12 months? Yes No

Have you had any bankruptcies in the past seven years? Yes No
(If yes, complete the Financial Supplement to Applicant for Life Insurance form.)

Have you (within the last five years), or do you (within the next two years) plan to engage
in skin diving (scuba or other), sky diving, mountain/rock climbing, horse racing, rodeo,
bull fighting, bungee jumping, BASE jumping, canyoneering, combat sports (boxing, mixed
martial arts or other), professional wrestling, extreme skiing/snowboarding or motor sports? Yes No
(If yes, complete the Sports and Avocations Statement form.)

Have you (within the last five years), or do you (within the next two years) plan to engage
in piloting an aircraft (including gliders, ultralight vehicles or any other type of airframe)? Yes No
(If yes, complete the Military Aviation Statement form.)

Owner information (if different than insured)

First name _____ Middle initial _____ Last name _____
DOB ____/____/____ Gender Male Female Phone number _____
Street address _____ City _____ State _____ Zip _____
County _____ Email _____
Driver's license number _____ Issue state _____ Expiration _____
SSN/Tax ID _____ - _____ - _____

EFT information

Bank name _____ Bank city _____
Bank state _____ Account type _____
Account number _____ Bank routing number _____

Beneficiary information

Beneficiary 1

First name _____
Last name _____
Relationship to insured _____
Percentage of death benefit _____

Beneficiary 2

First name _____
Last name _____
Relationship to insured _____
Percentage of death benefit _____

Insurance information

Type of insurance (business, personal) _____ Amount applied for \$ _____

Planned premium (permanent products) \$ _____

Agreements/Riders _____

Death benefit option Increasing Sum of premiums Level

Death benefit qualification Guideline Premium Test (GPT) Cash Value Accumulation Test (CVAT)

Existing insurance information

Death benefit amount \$ _____ Type of insurance _____

Is this a replacement? Yes No

Company _____

Policy number _____ Year issued _____

Questions?

Contact your financial professional.

Please note additional information may be required, depending upon the specific case.
This form contains sensitive client information and should only be sent over an encrypted email server.



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