Client Data Form

MADISON™ BROKERAGE
The Advisor's Advisor

PROPOSED INSURED INFORMATION

First Name: _____ Middle Int.: _____ Last Name: _____

State: _____ DOB: ___ / ___ / ___ Gender: ○ M ○ F Coverage Amount: $ _____

Term Years: _____ Is this a replacement? ○ Y ○ N Will the insured own this policy? ○ Y ○ N

Riders: ☐ Accidental Death Benefit ☐ Waiver of Premium ☐ Child Term Amount: $ _____ *($1,000 increments up to $25,000)*

CLIENT INFORMATION

___ - ___ - _____ SSN #
(___) ___ - ____ Home Phone
(___) ___ - ____ Mobile Phone
_____ Driver's License #
__ / __ / ____ License Exp. Date
_____ License State

_____ Email Address
_____ Address
_____ City
_____ State
_____ Zip

_____ Owner's Full Name *(If other than insured)*
___ / ___ / _____ DOB or Trust Date
___ - ____ - ____ SSN # / TIN #
_____ Relationship
_____ Email Address

_____ Address *(If other than insured)*
_____ City
_____ State
_____ Zip

Is the client a U.S. Citizen? ○ Y ○ N Purpose of Insurance: ○ Personal ○ Business

Income: $ _____ Net Worth: $ _____ Assets: $ _____

EXISTING/PENDING COVERAGE

Does the client have any existing or pending life insurance or annuities? *If yes, please fill in the fields below.* ○ Y ○ N

Carrier	Amount	Policy Number	Issue Year	Beneficiary	Replacement
_____	$_____	_____	_____	_____	○ Y ○ N
_____	$_____	_____	_____	_____	○ Y ○ N

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your exist policy or contract? ○ Y ○ N

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ○ Y ○ N

Reason for replacement: _____

BENEFICIARY INFORMATION

Name/Relationship	Primary/Contingent	Percent	DOB	SSN # / TIN #
_____	_____	_____	___ / ___ / _____	____ - __ - _____
_____	_____	_____	___ / ___ / _____	____ - __ - _____

AGENT ONLY SECTION

What is the source of funds for the initial premium? _____

What is the source of funds for future premiums? _____

Did you see the proposed insured at point-of-sale? ○ Y ○ N

Is the proposed insured an active duty service member of the US Armed Forces (including National Guard and Reserve)? ○ Y ○ N

Is the policyowner, or the person to whom this policy was sold, an active duty service member of the United States Armed Forces (including National Guard and Reserve)? ○ Y ○ N

HEALTH INFORMATION

1.) Height: _____ feet _____ inches 2.) Weight: _____ lbs *(current weight plus 1/2 of any weight loss in the last year)*

3.) Does the proposed insured use or have they ever used tobacco or nicotine? _____

3a.) If yes, what type, frequency and when last used? _____

3b). If cigar use will the insured test positive for nicotine? _____

4.) Has any parent or sibling of the proposed insured had, been diagnosed with, or died from cardiovascular disease and/or cancer prior to age 65? *If yes, fill out the following for each applicable parent and/or sibling:* ○ Y ○ N

Relationship	Age at Death or Diagnosis	Type: Cardiovascular or Cancer	Result: Death or Diagnosis
_____	_____	_____	○ Death ○ Diagnosis
_____	_____	_____	○ Death ○ Diagnosis
_____	_____	_____	○ Death ○ Diagnosis

5.) Has the client ever been told he/she has high blood pressure (hypertension)? ○ Y ○ N

5a.) Does the client currently take medication or have any history or treatment for high blood pressure? ○ Y ○ N

5b.) I f yes, what was the client's usual blood pressure reading for the past 6 months? ___ / ___

5c.) If the client does not know his/her reading, select the option that best describes his/her blood pressure over the past 12 months:

○ very well-controlled
○ reasonably well-controlled
○ not well-controlled

6.) Has the client had more than 3 speeding tickets and/or moving violations in the past 3 years; OR had a DUI, license suspension, or revocation in the past 5 years? ○ Y ○ N

7.) Has the client ever been diagnosed with, or received treatment/advice for, any of the following? ○ Y ○ N

AIDS, ARC, HIV positive
Emphysema/COPD
Liver Failure
Alcoholism
Epilepsy/Seizure Lupus
ALS (Lou Gehrig's Disease)
Gastric Bypass/Lap Band
Melanoma
Atrial Fibrillation Heart Attack
Multiple Sclerosis (MS) Barrett's EsophagusHeart Disease
Parkinson's Disease
Bipolar Disease
Heart Failure
Peripheral Artery/Vascular Disease (PAD)/(PVD)
Cancer (except certain skin cancers)
Heart Valve Replacement
Rheumatoid Arthritis (RA) Crohn's Disease
Hepatitis B
Sleep Apnea
Diabetes
Hepatitis C (active) Stroke/Transient Ischemic Attack (TIA)
Drug Abuse
Kidney Disease Ulcerative Colitis (UC)

7a.) If yes, please provide details: _____

_____

8.) Has the proposed insured used marijuana in the last 5 years? ○ Y ○ N

8a.) If yes, frequency and type: _____