

Insurance Information Request Form

FAX to: 408-269-8487



1. Your name _____

2. Telephone number () _____

3. Fax number (optional) () _____

4. Address _____

5. City - _____

State - _____ Zip Code - _____

6. Date of Birth - ____/____/____

7. Gender - Male or Female

8. Tobacco User - Non-Smoker or Smoker

9. Are you in good health? Yes or No (If not, please call 1-408-267-1003)

10. Select the type of insurance you're interested in: Term Insurance or Whole Life or Not Sure

11. What is the amount of insurance that you want? _\$ _____ or Not Sure

12. How many years do you require coverage? _\$ _____ or Not Sure

13. How many years do you plan to pay premiums? _\$ _____ or Not Sure

Please provide the following information for your spouse:

14. Name (first, middle initial & last) _____

15. Date of Birth - ____/____/____

16. Gender - Male or Female

17. Tobacco User - Non-Smoker or Smoker

18. In good health? Yes or No (If not, please call 1-408-267-1003)

17. Any comments or questions?