Financial Alternatives Inc.
INSURANCE & FINANCIAL SOLUTIONS THAT WORK

Life Insurance Questionnaire

Name: Date:

Date of Birth: Height: Weight:

E-Mail: Phone:

1) List **"current" in-force Life Insurance**, if any.

Face Amount: Insurance Co: Permanent or Term? Monthly Cost:

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2) **How much additional** Life Insurance do you feel you need?

3) How much can you **comfortably afford** to spend **Per Month?**

4) **How long** do you want your coverage to **last** (circle one)?

☐ 5-Years ☐ 10-Years ☐ 20-Years ☐ 30-Years ☐ Coverage you cannot outlive

5) **Smoker Status** (check all that apply)

Cigarette & E-Cigarette:

☐ Smoke **Currently** ☐ **Not in the Past 3 Years** ☐ **NEVER** Smoked

Pipe, Cigar, Smokeless:

☐ Smoke/Chew **Currently** ☐ **Not in the Past** 3 **Years** ☐ **NEVER** Smoked / Chewed

6) Do you have any **Health Issues** (i.e. blood pressure, cholesterol, etc.)? If 'Yes', briefly explain:

7) List any prescription medications below. Use reverse side if necessary.

Condition	Drug	Dosage	How Long Taken

8) Family Medical History (parents & siblings): List any conditions / diseases that run in your immediate family.

All information submitted is confidential. Send to or call:

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