

Jefferson National
JEFFERSON NATIONAL®

**Please fax or send
completed application (along with
this cover sheet) to:**

FAX:

1-608-755-7955

MAIL:

SAS

Simple Term

PO Box 1086

Janesville, WI 53547

Date

Name

phone number

email address

Agent ID#

To learn more please visit our websites at www.jeffersoninsurance.com or www.sas-it.com.
Jefferson National is domiciled in Dallas, TX, with offices in New York, NY in and Louisville, KY.
For Broker/Dealer and Agent use only. Not for public use.

Application for Life Insurance

1. Insured Information				Owner Information											
Name				Name											
Street Address				Street Address											
City		State		Zip		City		State		Zip					
e-mail			Phone			e-mail			Phone						
Sex M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth		Place of Birth				Sex M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth		Place of Birth			
Social Security Number				Driver's License # & State				Social Security Number							
Height		Weight													
feet		inches		lbs.											
2. Primary Beneficiary						Contingent Beneficiary									
Name				Relationship				Name				Relationship			
3. Plan Applied For		<input type="checkbox"/> Ten Years <input type="checkbox"/> Fifteen Years <input type="checkbox"/> Twenty Years <input type="checkbox"/> Thirty Years													
4. Coverage Amount		\$													
5. Payment Frequency		<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly													
6. Payment Method															
<input type="checkbox"/> Charge My Credit Card		<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express													
		Card Number				Exp.									
<input type="checkbox"/> Debit My Checking Account		Bank Name				Account Number				ABA Number					
		(first 9 numbers in the lower left-hand corner of your check – you may also attach a voided check)													
7. Replacement		Do you plan to replace, change or modify any existing life insurance as a result of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, additional forms may be required, depending upon state requirements)													
8. Underwriting															
1. In the past 12 months have you smoked cigarettes, cigars, pipes or used tobacco or nicotine in any form including snuff, dip, chew, nicotine patch, gum or other substitutes?										Y <input type="checkbox"/>		N <input type="checkbox"/>			
2. In the past 5 years, have you had or been treated for or consulted a physician or other practitioner for any of the following: heart or coronary artery disease or disorder, stroke, peripheral vascular disease, cancer, diabetes, hepatitis C, cirrhosis, pancreas disease or disorder, emphysema or chronic lung or pulmonary disease (COLD or COPD), alcohol or drug use?										Y <input type="checkbox"/>		N <input type="checkbox"/>			
3. In the past 5 years, have you been hospitalized for the following: chest pain, high blood pressure, asthma, depression, manic-depression, other mental and nervous disorder, paralysis, seizure, anemia, or kidney or liver disease or disorder (excluding kidney stones)?										Y <input type="checkbox"/>		N <input type="checkbox"/>			
4. In the past 2 years, have you had your driver's license revoked, suspended or been convicted of reckless driving, driving without a valid license or for driving while under the influence of alcohol or drugs (DWI, DUI)? Or have you been convicted of more than 2 moving violations in the past 12 months?										Y <input type="checkbox"/>		N <input type="checkbox"/>			
5. In the past or next 12 months, have you flown a plane other than as a commercial airline pilot?										Y <input type="checkbox"/>		N <input type="checkbox"/>			
6. The proposed insured does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" is defined and clarified in the Authorization section of this application. Have you ever received a diagnosis of, or treatment by a member of the medical profession for, AIDS, AIDS Related Complex (ARC) or the HIV Virus, or positive test results for antibodies to AIDS or the HIV Virus in the ELISA-WESTERN BLOT series? (Test results from anonymous or alternate test sites need not be revealed).										Y <input type="checkbox"/>		N <input type="checkbox"/>			
7. In the past 12 months, have you either been hospitalized for 5 or more consecutive days, or missed 5 or more consecutive days from work or school other than for vacation or family leave?										Y <input type="checkbox"/>		N <input type="checkbox"/>			

