

Trial Application



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 Schaumburg, IL 60173-4945
 Phone: 800.605.7566
 Fax: 847.619.9592
 www.resourcebrokerage.com

Broker's Name:	Broker's Phone:	Broker's Fax:
Broker's Email:	Return Quote by: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Email	Date Needed:

Primary Applicant's Name	Sex	DOB	SSN
Address			Phone
Height	Tobacco User?	If yes, what type?	
Weight		When last used?	

Type of Insurance Applying For		Amount	State of Issue
Replacement?	Previous Coverage Details	Total Amount of Insurance In Force	

Family History - Show age and present health, or if deceased, show age at death and cause of death.				
	Age	Present Health	Cause of Death	Age at Death
Father				
Mother				
Brother/ Sister				
Brother/ Sister				

Health Impairment(s)			
Medications and Dosage			

Physicians or Hospitals visited in last five years:			
	Name, Address, Phone Number	Date	Reason for Visit? Illness?
Primary Personal Physician			
Additional Physicians and/or Hospitals			

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Please complete applicable questionnaire(s):

Applicant Name: _____

Chest Pain Questionnaire	
Date of first episode of chest pain	Were you hospitalized?
Date of most recent episode of chest pain	
What was the final diagnosis made concerning your heart condition?	

By-Pass Surgery Questionnaire	
Date of by-pass surgery	Number of vessels by-passed
Heart attack before surgery?	Any chest pain since the by-pass operation?
Date of last exercise (stress) ECG	Results

Angioplasty Questionnaire	
Date of angioplasty	Date of previous angioplasty
Heart attack before angioplasty?	Chest pain since angioplasty procedure?
Date of last exercise (stress) ECG	Results

Diabetic Questionnaire		
Date of diagnosis of diabetes	Age at time of diagnosis	
Current Physician treating diabetes	Date of last visit	
Form of treatment	If Insulin, how many units per day? If Oral, type of medication and dosage per day?	
Date of last FBS (fasting blood sugar) test	Glucose reading	
Date of last A1-C (glycohemoglobin) test	A1-C reading	
Is home monitoring being done?		
Diabetic Complications - Any history of:		
High blood pressure?	Diabetic eye disease?	Heart disease?
Kidney disease?	Neurological disease?	

Cancer Questionnaire		
Date of diagnosis	Tumor location	
Pathology diagnosis		
What Stage?	What Group?	
Was there any lymph node involvement?	If yes, how many?	
Was there any metastasis (spread) to any other organ tissue?	If yes, please identify	
What kind of treatment?	Date of last treatment	

Aviation Questionnaire



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1. Proposed Insured _____

- (a) In the past 3 years have you been a pilot or received flying instructions? Yes No
- (b) Certificate Held Student Recreational Private Commercial ATP
- (c) Additional Ratings Instrument Multi-Engine Instructor Other (Describe in Section 8)
- (d) Medical Class First Second Third Date of Last Medical _____
- (e) Date of last flight as a Pilot _____

2. ESTIMATED FLIGHT HOURS

	Total Time	Last 12 months	Est. next 12 mos.
All Aircraft			
General Aviation Aircraft			
Scheduled Airline (Part 135 / 121)	N/A		
Student	N/A		
Military (Describe in Section 8)*			
Instrument (Actual & Simulated)	N/A		

* Only if describing current activity.

3. Have you ever been penalized for a violation of Federal Aviation Regulations? Yes No (If "Yes" give Details in Section 8)
4. Have you ever had an aviation accident or incident? Yes No (If "Yes" give Details in Section 8)
5. Are you flying under a waiver? Yes No (If "Yes" give Details in Section 8)
6. List all aircraft that you own, have flown in the past 3 years, or intend to fly: _____

7. In the past 3 years have you done :

- (a) Instruction of Students Yes No
- (b) Aerobatic Flying Yes No
- (c) Ultralight Flying Yes No
- (d) Agricultural Flying Yes No
- (f) Experimental Aircraft Yes No
- (g) Test Flying (For Hire) Yes No

(If "Yes" Describe type aircraft and hours flown)

8.

Comments: