



T R A D I T I O N
wealth management

Insurance Questionnaire

Date:

Mail To:
Tradition Wealth Management
Attn: Insurance Department
7601 France Avenue South, Suite 100
Edina, MN 55435

Fax To:
Tradition Wealth Management
Attn: Insurance Department
(952) 252-4648

Email To:
Tradition Wealth Management
rhondam@traditionwealthmanagement.com

Please contact us with any questions regarding the questions provided on this form at (952) 563-6500

Securities offered through ProEquities, Inc., a Registered Broker/Dealer, Member FINRA/SIPC.
Investment Advisory Services offered through Tradition Wealth Management, LLC, a Registered Investment Adviser.
Tradition Wealth Management, LLC, is independent of ProEquities, Inc. ProEquities, Inc. is not affiliated with Tradition Capital Bank.
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INSURANCE QUESTIONNAIRE (Personal and Confidential)

GENERAL INFORMATION

	<u>Client</u>	<u>Spouse (if applicable)</u>
Name:	_____	_____
Date of Birth:	_____	_____
U.S. Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Birth:	_____	_____
Social Security Number:	_____	_____
Driver License Number:	_____	_____
Driver License Expiration:	_____	_____
Driver License Issue Date:	_____	_____
Driver License State:	_____	_____

EMPLOYMENT

Occupation:	_____	Duties:	_____		
Annual Income:	_____	Any Unearned Income:	_____		
Employer:	_____	Years at Employer:	_____		
Employer's Address:	_____				
City:	_____	State:	_____	ZIP:	_____
Work Phone:	_____	Work Fax:	_____		
Work Email Address:	_____				

HOME

	<u>Current Address</u>	<u>Previous Address (if less than 3 years at current)</u>
Address:	_____	Address: _____
City:	_____	City: _____
	State: _____	State: _____
	ZIP: _____	ZIP: _____
Home Phone:	_____	
Home Fax:	_____	
Home Email Address:	_____	
Years at Address:	_____	

GENERAL PHYSICAL INFORMATION

Height:	_____	Weight:	_____
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CHILDREN

Number of Dependents (if applicable):	_____
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FINANCIAL INFORMATION

Total Assets:	_____	Total Liabilities:	_____
Net Worth:	_____	Tax Bracket:	_____

INSURANCE QUESTIONNAIRE

BENEFICIARY INFORMATION

Primary Beneficiary

Name: _____
Relationship: _____ Percentage: _____
SSN: _____ Date of Birth: _____

Secondary Beneficiary

Name: _____
Relationship: _____ Percentage: _____
SSN: _____ Date of Birth: _____

If Beneficiary is a Trust, please complete the following:

Name of Trust: _____ Date of Trust: _____
Name of Trustee: _____ Trust Tax ID: _____

EXISTING LIFE INSURANCE: (attach recent statement)

Company: _____
Face Amount: _____ Year Issued: _____
Company: _____
Face Amount: _____ Year Issued: _____

FAMILY HISTORY

	<u>Age if Living</u>	<u>Age at Death</u>	<u>Cause of Death</u>
Father	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____

To the best of your knowledge, is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disease?

If yes, please explain:

MEDICAL HISTORY

Doctor Name/Practice: _____ Phone Number: _____
Office Address: _____
Date Last Seen/Reason: _____
Treatment/Medication: _____

Doctor Name/Practice: _____ Phone Number: _____
Office Address: _____
Date Last Seen/Reason: _____
Treatment/Medication: _____

Have you ever been treated for cancer, diabetes, heart disorder, high blood pressure, mental or nervous disorders?

If yes, please explain:

INSURANCE QUESTIONNAIRE

MEDICAL INFORMATION

Yes No

Within the last 10 years, have you been told by a physician that you have had or have:

- Heart murmur, angina, heart attack, aneurysm, Transient Ischemic Attack (TIA), stroke or any other disease of the heart or arteries?
- Diabetes or disease of any glands?
- Depression, nervous breakdown, convulsions, epilepsy, paralysis, or any disease of the brain or nervous system?
- Arthritis, gout, or any bone, joint, muscle or skin disease?
- Asthma, emphysema, chronic obstructive lung disease or any other lung disease?
- Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or any other disease of the liver, gall bladder, pancreas, stomach or intestine?
- Prostate or testicular disease, disease of the uterus, ovaries, or breasts?
- Anemia, leukemia, clotting disease or platelet disease?
- Disease of the urinary tract or kidneys, sugar, albumin or blood in the urine?
- Cancer or tumors of any kind, malignant or benign?
- Within the last 10 years have you had** an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness or disease?
- Within the last 5 years have you had** any diagnostic tests (other than a routine blood pressure check, blood or urine test), including a treadmill stress test for any purpose, including insurance, whether conducted on an in-patient or out-patient basis?
- Do you currently have medical concerns for which you have not consulted a physician or any consultation, testing or investigation recommended by a physician which has not yet been completed?

Do you consume alcoholic beverages?

<input type="checkbox"/> Never	<input type="checkbox"/> Currently	<input type="checkbox"/> In the past
Complete if ' Currently ' was selected		
Type of beverage	Frequency	Quantity
Complete if ' In the past ' was selected		
Date Stopped:	Month	Year
Reason Stopped:		

INSURANCE QUESTIONNAIRE

NON-MEDICAL INFORMATION

Yes

No

- Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company?
- Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for?
- Within the last 5 years, have you been convicted of reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended?
- Do you plan to travel or reside outside the U.S. in the next 2 years?

If yes, where? _____

- Have you submitted a disability claim to any insurance in the past 5 years?
- Do you fly other than as a passenger on commercial airlines?
- Do you skin or scuba dive, hang glide, parachute, balloon or motor race on land or water?
- Have you ever had a policy for life or health insurance declined or rated in the last 5 years?
- Have you ever used any kind of tobacco?

If yes, has use been discontinued? Yes No If yes, date it was discontinued: _____

- Within the last 5 years, have you filed for bankruptcy (personal or business)?
- Have you ever been convicted of a felony, or are you currently on probation or parole?
- Are you a member of or do you contemplate joining the Armed Forces or an active/reserve military unit?

If you answered 'Yes' to any of the questions listed above, please provide details: