

# UT Resident Life Insurance Program

(Please print)

## General Information

Name \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Birthdate \_\_\_\_\_

Street \_\_\_\_\_ Birthplace (state or country) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Medical Specialty \_\_\_\_\_ Driver's License Number/State \_\_\_\_\_

PGY (Please Circle) 1 2 3 4 5 6 7

## Health Information

Height \_\_\_\_\_ Weight \_\_\_\_\_ Have you lost any weight in the past year? Yes \_\_\_\_ No \_\_\_\_

1. Have you used any kind of tobacco products in the past 36 months? Yes \_\_\_\_ No \_\_\_\_
2. Have you EVER been treated for or had any known indication of:
  - a. Disease or disorder of the heart or circulatory system, lungs, kidney, stomach, intestines, liver, thyroid, bladder, genital or reproductive organs, brain or nervous system, skin, eyes or speech? Yes \_\_\_\_ No \_\_\_\_
  - b. Disease or disorder, injury, strain or sprain involving the bones, joints, muscles, ligaments, knees, back or neck? Yes \_\_\_\_ No \_\_\_\_
  - c. Ever been treated for or been diagnosed as having a deficiency of the immune system such as acquired immune deficiency syndrome? Yes \_\_\_\_ No \_\_\_\_

If yes to any of the above questions, please give details: \_\_\_\_\_

---

## Beneficiary Information

Primary \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent \_\_\_\_\_ Relationship \_\_\_\_\_

## Additional Information

1. Have you ever been rated, declined, or postponed for life insurance? Yes \_\_\_\_ No \_\_\_\_
2. Do you intend to replace or change any existing insurance policy? Yes \_\_\_\_ No \_\_\_\_
3. If yes, what life insurance do you currently have in force?  
Company \_\_\_\_\_ Amount \_\_\_\_\_ Date Issued \_\_\_\_\_
4. Are you interested in having a quote on a permanent plan that accrues cash value?  
Yes \_\_\_\_ No \_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_