PHYSICIAN DATA FORM

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COMPLETION OF THIS FORM WILL EXPEDITE THE UNDERWRITING PROCESS

Proposed Insured Name	Date of Birth

Advisor Name

Please list any medications you are taking*

Medication
Prescribing Physician
Date of Last Check-up

Medication
Prescribing Physician
Date of Last Check-up

Medication
Prescribing Physician
Date of Last Check-up

Medication
Prescribing Physician
Date of Last Check-Up

Medication
Prescribing Physician
Date of Last Check-up

Medication
Prescribing Physician
Date of Last Check-up

Please list any physicians you have visited in the last 10 years*

Physician's Name
Address
City State ZIP
Phone Number
Date and Reason of Last Visit
Treatment / Medication
Follow Up Plans

Physician's Name
Address
City State ZIP
Phone Number
Date and Reason of Last Visit
Treatment / Medication
Follow Up Plans

Physician's Name
Address
City State ZIP
Phone Number
Date and Reason of Last Visit
Treatment / Medication
Follow Up Plans

Physician's Name
Address
City State ZIP
Phone Number
Date and Reason of Last Visit
Treatment / Medication
Follow Up Plans

*Please use a duplicate form if additional data exists