WEALTH WATCH PARTNERS

DI Information Questionnaire

Personal Information (Proposed Insured)

First Name:________________Middle Initial:________Last Name:______________________________

DOB:_________/______/______Gender: ☐ Male ☐ Female

State of Solicitation:_______________County or Residence: ____________________

Birth Country:_____________________Birth State (U.S.):________________________

Citizenship:_______________________SNN/Tax ID:_________–____________–____________

Are you an active duty member of the U.S. Armed Services? ☐ Yes ☐ No

Driver's License Number:_________________Issue State:_________Expiration:_________________

Earned Income: $________________________Total Net Worth: $______________________________

Liquid Net Worth: $______________________

Are you employed? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

Occupation:_____________________________Years in Occupation:______________

Occupation Duties:____

Percentage of Income to be Replaced:____________

Contact Information

Home Phone:_____________________Cell Phone:_______________________

Street Address:__________________________City:________________State:________Zip:__________

Country:__________________________Email:____

Health & Lifestyle (Proposed Insured)

Current Height:______ft._____in. Current Weight:______lbs.

Tobacco Use: ☐ Yes ☐ No

Wealth Watch Partners

List known medical conditions:

____

____

____

List all prescribed medications and dosage:

____

____

____