

# Life Insurance No Medical Exam Application

## Personal Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Policy Details

Type of Policy: (e.g., Simplified Issue, Guaranteed Issue) \_\_\_\_\_

Coverage Amount Desired: \_\_\_\_\_

Policy Term (if applicable): \_\_\_\_\_

## Employment and Income Information

Occupation: \_\_\_\_\_

Annual Income: \_\_\_\_\_

Employer Name (if applicable): \_\_\_\_\_

## Beneficiary Information

Primary Beneficiary Full Name: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Secondary Beneficiary Full Name (if applicable): \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

## Health and Lifestyle Information

Do you smoke or use tobacco products?

Yes

No

**Have you been diagnosed with any major health conditions?**

Yes

No

- If yes, please specify: \_\_\_\_\_

**List any current medications:**

\_\_\_\_\_

**Family history of heart disease, cancer, or diabetes?**

Yes

No

## **Policy Questions**

**Why are you seeking a no medical exam life insurance policy?**

**Have you been denied life insurance in the past?**

Yes

No

- If yes, please explain: \_\_\_\_\_

## **Acknowledgment and Signature**

**I hereby declare that the information provided is true and accurate to the best of my knowledge. I understand that any false statements may result in the denial of coverage or future claims.**

**Applicant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Agent/Representative's Signature (if applicable):** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Note:** This template is a general guide and may need to be adjusted to fit specific insurance providers' requirements. Always review the terms and conditions of the insurance provider before submitting an application.