QUESTIONNAIRE: FOREIGN TRAVEL

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never

☐ Former Date Stopped: _____

☐ Current Type: _____

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL

☐ WL ☐ VUL ☐ Survivorship

Face Amount: _____

Premium Tolerance: _____

Occupation		Company:
Income		Location of work and duties:
Citizenship		
US Visa Type & Expiration		
Current Residence		
Primary Residence		
Location of owned home(s)		
Location of Physician		

Travel: Prior Twelve Months			
City/Country	Reason	Number of Trips/Dates	Total Days

Travel: Next Twelve Months			
City/Country	Reason	Number of Trips/Dates	Total Days

Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: _____