SNAPApp Worksheet

1. PROPOSED INSURED'S INFORMATION

Insured's Name — First / Last / MI

DOB ___ / ___ / ___ Gender ☐ F ☐ M SSN

License State | Number
May not be required for all carriers but should be collected

State of Residence

At least one phone field is required.

Home Phone Number ___ - ___ - ___ Mobile Phone Number ___ - ___ - ___

Work Phone Number ___ - ___ - ___ Email

Primary Address — City / State / Zip Code

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No

Will the insured own this policy? If no, completion Ownership Section. ☐ Yes ☐ No

Purpose of Insurance ☐ Personal ☐ Business

2. PROPOSED COVERAGE *Additional Carrier or State specific questions may be asked on the drop ticket.*

Term Years ___ Coverage Amounts $ ___

Term Years ___ Coverage Amounts $ ___

Term Years ___ Coverage Amounts $ ___

Riders

☐ Accidental Death Benefit ☐ Waiver of Premium ☐ Child Term # of Units for Child Rider ___

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No

2. PROPOSED COVERAGE cont.

Reason for replacement

Total accidental death insurance in force with all companies $

Does the client have any existing or pending life insurance of annuities? ☐ Yes ☐ No
If Yes, please fill in the information below.

Carrier	Amount	Policy Number	Issue Year	Replacement
	$			☐ Yes ☐ No
	$			☐ Yes ☐ No
	$			☐ Yes ☐ No

3. POLICY OWNERSHIP

Owner's Name

SSN/TIN

DOB or Trust Date / /

Email

Phone Number - -

Primary Address City State Zip Code

Relationship to Insured

4. BENEFICIARY INFORMATION *The total should equal 100% per beneficiary type.*

Name/Relationship	Primary/Contingent	Percent	DOB	SSN/TIN *Optional from drop ticket submission but may be required before policy issue*
				- -
				- -
				- -

5. TO BE COMPLETED BY AGENT

What is the source of funds for the initial premium?

What is the source of funds for future premiums?

How long have you known the Proposed Insured?

Are you related to the Proposed Insured? ☐ Yes ☐ No

5. TO BE COMPLETED BY AGENT cont.

Did you see the proposed insured at point-of-sale? ☐ Yes ☐ No

Is the proposed insured an active-duty service member of the US Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No

Is the Proposed Insured using income from their spouse/domestic partner to justify the coverage applied? ☐ Yes ☐ No

Is the policy owner or the person to whom this policy was sold an active-duty service member of the US Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No

If Yes, what is the spouse/domestic partner's annual income? $

If Yes, how much life insurance does the spouse/domestic partner have in force? $

Do the proposed insured and owner read and understand the English language? ☐ Yes ☐ No

Proposed Insured Annual Income / Net Worth $ $
Required for John Hancock only

OPTIONAL information is not required for quoting or submission.

Engaged in scuba diving, sky sports, mountain, rock, cliff, ice climbing or motorsport events? ☐ Have in the last 5yrs ☐ Plan to in the next 2 years

Plans to travel outside the U.S. in the next 2 years? ☐ Yes ☐ No If Yes, When:

Have flights been booked? ☐ Yes ☐ No

Additional Comments

6. HEALTH INFORMATION (OPTIONAL) *Needed only when using Vive's Health Analyzer*

Height Feet Inches

Weight *(Current weight plus ½ of any weight loss in the last year)* lbs.

Has the proposed Insured ever been diagnosed with high blood pressure (hypertension)? ☐ Yes ☐ No

Does the proposed insured currently take medication or have any history or treatment for high blood pressure? ☐ Yes ☐ No

If Yes, what was the proposed insured's usual blood pressure reading for the past 6 months?

If the proposed insured does not know their reading, select the option that best describes their blood pressure over the past 12 months? ☐ Very Well Controlled ☐ Reasonably Well Controlled ☐ Not Well Controlled

Does the proposed insured use or have ever used tobacco or nicotine (Includes cigar use)? ☐ Yes ☐ No

If Yes, what type, frequency and when was it last used?

If cigar use, will the insured test positive for nicotine? ☐ Yes ☐ No

Has any parent or sibling of the proposed insured had, been diagnosed with, or died from cardiovascular disease and/or cancer prior to the age 65? ☐ Yes ☐ No

If Yes, fill out the following for each applicable parent and/or sibling:

Relationship	Age at Death or Diagnosis	Type	Result
		☐ Cancer ☐ Cardiovascular	☐ Death ☐ Diagnosis
		☐ Cancer ☐ Cardiovascular	☐ Death ☐ Diagnosis
		☐ Cancer ☐ Cardiovascular	☐ Death ☐ Diagnosis
		☐ Cancer ☐ Cardiovascular	☐ Death ☐ Diagnosis

Has the proposed insured ever been diagnosed with or received treatment/advice for any of the following?

- ☐ AIDS, ARC, HIV Positive
- ☐ ALS (Lou Gehrig's Disease)
- ☐ Alcoholism
- ☐ Atrial Fibrillation
- ☐ Barrett's Esophagus
- ☐ Bipolar Disease
- ☐ Cancer (except certain skin cancers)
- ☐ Crohn's Disease
- ☐ Diabetes (including Gestational)
- ☐ Drug Use
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizure
- ☐ Gastric Bypass/Lap Band
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Valve Replacement
- ☐ Hepatitis B
- ☐ Hepatitis C (active)
- ☐ Kidney Disease
- ☐ Liver Failure
- ☐ Lupus
- ☐ Melanoma
- ☐ Multiple Sclerosis (MS)
- ☐ Parkinson's Disease
- ☐ Peripheral Artery/Vascular Disease
- ☐ Rheumatoid Arthritis (RA)
- ☐ Sleep apnea
- ☐ Stroke/Transient Ischemic Attack (TIA)
- ☐ Ulcerative Colitis (UC)

Has the proposed insured had more than 3 speeding tickets and/or moving violations in the past 3 years or had a DUI, license suspension or revocation over the past 12 months? ☐ Yes ☐ No

Not required for quoting or order submission

Has the proposed insured used marijuana in the last 5 years? If yes, specify: ☐ Yes ☐ No Frequency

Type   Date Last Used

Has the proposed insured ever had an application for life or health insurance declined, postponed, or rated or offered other than as applied for? ☐ Yes ☐ No

OPTIONAL: Medication information is NOT required for quoting or order submission.
Does the proposed insured currently take any prescription medications? ☐ Yes ☐ No

If Yes, provide prescription information such as name & dosage, reason prescribed, and date condition was diagnosed.

Prescription Name	Dosage	Reason