SFG BROKERAGE
a MassMutual partner

EZ-app Guide for Life & Disability Income Insurance

Application Type:

☐ Life & Disability Income (Review all sections)

☐ Life only (Review sections A-F)

☐ Disability Income only (Review sections A-B & G-H)

Product desired: _____ Billing Frequency: _____ Illustration attached? _____

Broker Information:

Name: _____ Phone: _____

Email: _____

A – Proposed Insured Information

Full name: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Birth state: _____ SSN/ITIN: _____

Residential address: _____

Phone 1: _____ ☐ Home ☐ Work ☐ Cell Best time to call: _____

Email 1: _____

Type of citizenship: ☐ Resident U.S. citizen ☐ Non-resident U.S. citizen ☐ Resident alien ☐ Other: _____

Additional Citizenship Information (Non-U.S. Citizens only): Country of citizenship: _____

Type of visa: _____ How long have they lived in the U.S. on a full time basis? _____

What members of their immediate family are full time residents in the U.S. or citizens of the U.S.? _____

_____

Client DL #: _____ State _____

Bank name: _____

Account # _____ Routing #: _____

B – Personal History

More information will need to be provided at time of application if the Proposed Insured:

Yes	No	
☐	☐	Is currently disabled or applying for any disability benefits
☐	☐	Has used tobacco or other nicotine containing products (e.g. cigarettes, e-cigarettes, pipes, cigars, snuff, chewing tobacco or nicotine delivery device such as gum or the patch) within the last 24 months
☐	☐	Has ever been convicted of a felony, or is currently on parole or probation
☐	☐	Has been convicted of operating a motor vehicle while under the influence within the last 5 years
☐	☐	Has been found at fault in a motor vehicle accident, convicted of a moving violation or received a driver's license restriction or revocation (e.g. speeding ticket, suspended license, reckless driving or careless driving) within the last 3 years
☐	☐	Has any recent/anticipated foreign travel (**If yes**, list country: _____ and date(s) of travel: _____)
☐	☐	Has any recent/anticipated military involvement
☐	☐	Has any recent/anticipated aviation experience (e.g. pilot, student pilot, crew member)
☐	☐	Has any recent/anticipated avocation participation (e.g. extreme sports)

B – Personal History (Continued)

Physician name: _____

Physician address: _____

Date/timeframe/reason last seen: _____

Insurance occupation & job duties: _____

Employer name & address: _____

_____

Household annual earned income: $ _____ Prior year: $ _____

Household annual unearned income: $ _____ Prior year: $ _____

Household net worth: $ _____

If juvenile, list all family members (including siblings, parents and legal guardians). For coverage, provide the total life insurance currently applied for or now in force with MassMutual or other companies. If none, more information will need to be provided at time of application.

Relationship	Name	Age	Group Coverage In Force	Non-Group Coverage In Force
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

For juvenile apps, please see section I for non-med questions

C – Owner Information (Life only; information needed if Proposed Owner is not Proposed Insured)

Full name: _____

Gender: ☐ Male ☐ Female Driver's License #: _____ State: _____

SSN/EIN: _____ Date of birth/date of Trust: _____

Relationship to Insured: _____ Trustee: _____

Residential/legal address: _____

For company-owned, please see business life supplement

D – Beneficiary Information (Life only)

Beneficiary 1 **Type:** ☐ Primary ☐ Secondary/Contingent ☐ Not sure

Full name: _____

Date of birth/date of Trust: _____ Relationship to Insured: _____

Residential address: _____

Beneficiary 2 **Type:** ☐ Primary ☐ Secondary/Contingent ☐ Not sure

Full name: _____

Date of birth/date of Trust: _____ Relationship to Insured: _____

Residential address: _____

Space for additional beneficiary on next page.

Beneficiary 3 **Type:** ☐ Primary ☐ Secondary/Contingent ☐ Not sure

Full name: _____

Date of birth/date of Trust: _____ Relationship to Insured: _____

Residential address: _____

E – Supplemental Information for Proposed Insured (Life only)

If any of the questions below are answered 'yes,' additional information will be required at time of application:

Have they been treated for, or had treatment recommended by, a health professional for cancer, heart attack, heart disease, chest pain, stroke, alcohol or drug use or immune system disorder within the past two years? ☐ Yes ☐ No

Have they been admitted to a hospital or medical facility, been advised to be admitted, or had surgery performed or recommended by a health professional other than for a normal pregnancy or childbirth within the past 90 days? ☐ Yes ☐ No

Have they had medical tests or examinations scheduled in the next 90 days except for pregnancy or childbirth? ☐ Yes ☐ No

F - Other Life/Annuity Coverage on Proposed Insured (Life only)

Policy # & Company	Face Amount	Product	Issue Yr.	Purpose	Status	Replace	1035x
_____	$ _____	_____	_____	☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No
_____	$ _____	_____	_____	☐ Business ☐ Personal	☐ Applied for ☐ In force	☐ Yes ☐ No	☐ Yes ☐ No

G – Supplemental Information for Proposed Insured (Disability Income only)

What percent of their duties include physical activity (e.g. climbing, crouching, lifting, etc.)? _____

What state do they work in? _____ How long have they worked for their current employer? _____

If less than 2 years, what was their previous occupation and duration of employment? _____

How many hours per week, on average, do they work? _____

For the past 90 days, have they been continuously at work? ☐ Yes ☐ No If no, provide details of missed work, reduced hours or job restrictions/modifications: _____

Is additional contributory group disability income coverage available through their employer?

☐ Yes ☐ No ☐ Not sure If yes, do they have plans to participate in the future? ☐ Yes ☐ No ☐ Not sure

H - Other Disability Income Coverage on the Proposed Insured (Disability Income only)

Company	Type*	Issue Yr.	Monthly Benefit Amount	Benefit Period	Waiting Period	Employer pay?	Being replaced?	Replacement Date
_____	_____	_____	$ _____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	_____	_____	$ _____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	_____

*Type of plan: Individual (I), Group (G) or Association (A)

I - Personal Information (Non-Med)

Current height (Feet and Inches): _____ Current weight (Pounds): _____

Has your weight changed by more than 10 pounds in the last year? ☐ Yes ☐ No

If Yes, how much? _____ Due to? ☐ Diet ☐ Other

Family History:
Complete all sections of the grid below, except "Diagnosis", for all immediate family members (parents and siblings):

Relative	Diagnosis - Include Age of Onset	Age if Living	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

Have any of the family members listed above been diagnosed or treated by a member of the medical profession for:

Heart Disease, vascular (blood vessel) disease or cancer? ☐ Yes ☐ No

A familial condition of the brain, muscles, nervous system or kidneys? ☐ Yes ☐ No

Yes	No	
☐	☐	Is the Proposed Insured currently under treatment by a member of the medical profession or taking any prescription medications (other than contraceptives)? (**If yes**, list the name of the prescriber: _____)
☐	☐	Has the Proposed Insured had any medical conditions or procedures in the past 10 years? (**If yes**, please give more information: _____ _____)
☐	☐	Does the Proposed insured have any known medical procedures coming up? (**If yes**, please give more information: _____ _____)

J - Business Information

Business type (*select one*):

☐ Corporation ☐ S-Corporation ☐ LLC/LLP ☐ Partnership ☐ Sole Proprietor ☐ Non-Profit

A. Year established: _____ C. Number of employees: _____

B. Estimated net value: $_____ D. Percentage of company owned: _____%

Does the business carry life insurance on the lives of any business officer(s) or partner(s)? ☐ Yes ☐ No
If Yes, complete the following table listing the total life insurance (including group coverage with employer) currently applied for or now in force in all companies. If No, explain in the Details box below.

Name	Title	Face Amount	% Owned
		$_____	_____%
		$_____	_____%
		$_____	_____%
		$_____	_____%
		$_____	_____%