

Producer #: \_\_\_\_\_

## KEY PERSON FAILURE TO SURVIVE APPLICATION FORM

Policy Owner/Beneficiary (Not the Insured): \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address of Policy Owner: \_\_\_\_\_  
 Type of Business: \_\_\_\_\_  
 Requested Benefit Amount: \$ \_\_\_\_\_

## PROPOSED INSURED PERSON INSURABILITY

**This section must be completed by the proposed insured person.**

Name of Insured Person: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Daily Duties: \_\_\_\_\_  
 Period of Insurance: \_\_\_\_\_

**If "Yes" is answered for any of the following questions, please provide full details in the space below. If there is not sufficient space, please attach your answers on a separate sheet.**

1. Do you have any physical health problems or suffer from, been diagnosed with, received treatment for, or been prescribed treatment for any condition related to, or from a sickness of any kind?  Yes  No
2. Have you ever been diagnosed with a heart condition, high blood pressure, diabetes or cancer?  Yes  No
3. Have you at any time been physically or mentally unable to work during the last 12 months?  Yes  No
4. Have you ever been declined, postponed, or accepted on special terms for life, accident or illness insurance?  Yes  No
5. Do you intend to engage in hazardous sports or any activities that expose you to personal injury?  Yes  No
6. Any foreign travel planned during the proposed period of insurance? *If "Yes", please include location(s), anticipated length, and frequency of travel.*  Yes  No
7. Do you hold a valid pilot license? *If "Yes", please include average piloting hours and type(s) of aircraft to be flown.*  Yes  No
8. Have you ever had any criminal convictions?  Yes  No

**Details to the answers above:** \_\_\_\_\_

## FINANCIAL INSURABILITY

Total anticipated financial loss from death of the key person: \$ \_\_\_\_\_

**Please provide a breakdown of how you will suffer a financial loss in the event of death of the Key Person along with any supporting financial documentation:**

1. Loss of revenue: \$ \_\_\_\_\_
2. Costs which will be incurred to find a replacement: \$ \_\_\_\_\_
3. Cost of temporary replacement staff: \$ \_\_\_\_\_
4. Key person's share of ownership: \$ \_\_\_\_\_ & \_\_\_\_\_ %
5. Loss of future accounts: \$ \_\_\_\_\_
6. Other (please provide additional detail): \$ \_\_\_\_\_

**Declaration (The Applicant must read this before signing)** I am aware that the policy wording contains exclusions in coverage in respect of AIDS, HIV, suicide, alcohol and drugs. To the best of my knowledge and belief the information provided in connection with this application, whether in my own hand or not, is true and I have not withheld any material fact. I understand that non-disclosure or misrepresentation of a material fact will entitle underwriters to void this insurance. (A material fact is one likely to influence acceptance or assessment of this application by underwriters.

Insured's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_