



**Vital Guidance: A Life Management Company**

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Tampa, Florida 33602

**INFO CHECKLIST  
FOR ILLUSTRATION**

Applicant's name \_\_\_\_\_ Resident state \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Benefit amt. Elimination Benefit period

Do you have disability income now (including coverage through an employer) with another provider?  Yes  No \_\_\_\_\_

Have you ever filed for bankruptcy? \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Job duties (be specific) \_\_\_\_\_

W2 employee or self-employed? \_\_\_\_\_ If W2 employee, list monthly income \$ \_\_\_\_\_

**If self-employed:** For how long? \_\_\_\_\_ What percentage of the company do you own? \_\_\_\_\_

How many employees are employed by the business? \_\_\_\_\_

Do you work out of your home?  Yes  No If YES, what percentage of time do you work from home? \_\_\_\_\_

Taxable earned income for this year \$ \_\_\_\_\_ Last year \$ \_\_\_\_\_

Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_\_  Male  Female

Has the Proposed Insured had a change in weight of more than 10 pounds this past year?  Yes  No

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum?  Yes  No

If YES, please list type \_\_\_\_\_ amount per day \_\_\_\_\_ last date of use \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you currently taking any prescribed medications, or in the past three years have you been prescribed any medications?  Yes  No

Medication	Daily Dosage	Date Originally Prescribed

Back and/or neck problems?  Yes  No Chiropractic treatment?  Yes  No Last date seen \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you ever participated in a sleep study, been diagnosed with sleep apnea or other respiratory disorder, or ever used a c-pap machine?  Yes  No

Diabetes?  Yes  No  Type I  Type II Age at onset \_\_\_\_\_

Hypertension?  Yes  No Date of diagnosis \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last reading \_\_\_\_\_, date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Skin cancer or tumors?  Yes  No Type and location \_\_\_\_\_ Last treatment date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Drug and/or alcohol abuse?  Yes  No Type of drug \_\_\_\_\_ Amount of alcohol \_\_\_\_\_

Treatment dates \_\_\_\_\_ Involvement in support groups  Yes  No Which? \_\_\_\_\_

Have you had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60?  Yes  No

If YES, list relationship, diagnosis and age of diagnosis. \_\_\_\_\_

Other medical history:

Elimination period requested \_\_\_\_\_ Benefit period requested \_\_\_\_\_

Agent's name \_\_\_\_\_ Phone no. \_\_\_\_\_ Email \_\_\_\_\_