MassMutual FINANCIAL GROUP®

Massachusetts Mutual Life Insurance Company
1295 State Street, Springfield, MA 01111-0001

Life Fact Finder for Individuals

Email

Personal Information

Full name: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Birth state: _____

Residential address: _____

Phone: _____ ☐ Home ☐ Work ☐ Cell

Email: _____ SSN/ITIN: _____

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

Country of citizenship: _____ Type of visa: _____ Visa number: _____

How long have you lived in the U.S. on a full time basis? _____

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

Type of Government ID: ☐ U.S. Driver's License ☐ Passport ☐ Other: _____

ID number: _____ State/country issued: _____

Have you used tobacco or other nicotine containing products within the last 24 months? ☐ Yes ☐ No ☐ Not sure

Have you ever been convicted of a felony, or are you currently on parole or probation? ☐ Yes ☐ No ☐ Not sure

Have you been found at fault in a motor vehicle accident or moving violation within the last 3 years? ☐ Yes ☐ No ☐ Not sure

Occupation & job duties: _____

Employer name: _____

Employer address: _____

Annual earned income: $ _____ Annual unearned income: $ _____ Net worth: $ _____

Recent/anticipated foreign travel? *If Yes, provide details in the Notes section.* ☐ Yes ☐ No ☐ Not sure

Recent/anticipated military involvement? ☐ Yes ☐ No ☐ Not sure

Recent/anticipated aviation experience (e.g. pilot, student pilot, crew member)? ☐ Yes ☐ No ☐ Not sure

Recent/anticipated avocation participation (e.g. extreme sports)? ☐ Yes ☐ No ☐ Not sure

Physician name: _____

Physician address: _____

Date last seen: _____ *List any prescriptions in the Notes section*

Have you 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 you 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

Do you have medical tests or examinations scheduled in the next 90 days except for pregnancy or childbirth? ☐ Yes ☐ No

Owner Information

Full name: _____ SSN/ITIN/EIN: _____

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

Residential address: _____

Beneficiary Information

Beneficiary 1 Type: ☐ Primary ☐ Contingent ☐ Not sure

Full name: _____ SSN/ITIN/EIN: _____

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

Residential address: _____

Beneficiary 2 Type: ☐ Primary ☐ Contingent ☐ Not sure

Full name: _____ SSN/ITIN/EIN: _____

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

Residential address: _____

Beneficiary 3 Type: ☐ Primary ☐ Contingent ☐ Not sure

Full name: _____ SSN/ITIN/EIN: _____

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

Residential address: _____

Other Coverage

Complete the table below if there is any other life, annuity or long term care coverage in force or applied for:

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

Notes

For foreign travel, provide purpose of travel, family involvement, expected date of departure, and countries/cities being visited, including durations.

_____

_____

_____

_____

_____