



Trinity Life Insurance Company

ADMINISTRATIVE OFFICE
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AVIATION QUESTIONNAIRE

PRINT USING BLACK INK.
ALL SECTIONS MUST BE COMPLETED.

Name of Proposed Insured: _____ Date of Birth: _____

SECTION 1 HOURS FLOWN	For Pilots, Students and Crew Members: Total of Solo Hours Flown _____ Total Hours Flown _____ Estimated Hours Flying _____ as Pilot or Crew Member: _____ In Past 12 Months: _____ In Next 12 Months: _____
SECTION 2 PILOT LICENSE	Pilot Certificate currently held: <input type="checkbox"/> Private <input type="checkbox"/> Instrument Flight Rating (IFR) <input type="checkbox"/> Student <input type="checkbox"/> Commercial <input type="checkbox"/> Airline Transport Rating (ATR) <input type="checkbox"/> Flight Instructor In the past 10 years have you been grounded or had your license revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", give details in Remarks Section below.)
SECTION 3 TYPE FLYING	Type of Flying: <input type="checkbox"/> Pleasure <input type="checkbox"/> Freight Carrying or Passenger Service <input type="checkbox"/> Personal Business <input type="checkbox"/> Employer Aircraft or Employee Transportation <input type="checkbox"/> Crop Dusting <input type="checkbox"/> Other (Give details in Remarks Section below.) <input type="checkbox"/> Instructor
SECTION 4 MEDICAL CERTIFICATE	a. Medical Certificate currently held: <input type="checkbox"/> Class III <input type="checkbox"/> Class II <input type="checkbox"/> Class I b. Date of last renewal: Month _____ Day _____ Year _____ c. Was it denied by the Aviation Medical Examiner but eventually issued? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Was it necessary to appeal before Certificate was eventually issued? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Was Medical Certificate granted subject to limitation(s) or physical waiver(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If any of the above questions is answered "Yes", please give details in Remarks below.)
SECTION 5 MILITARY FLYING	a. Military Branch or Organization: _____ b. Type Aircraft: _____ Date of Last Flight: _____ c. If not pilot, specify capacity in which you fly: _____
SECTION 6 OTHER FLYING	Other Type of Flying: a. Have you, in the past 10 years, flown or do you intend to fly in the next 2 years: Ultralight, Biplane, Prototype, experimental or personally built or assembled aircraft? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", complete Avocation Questionnaire.) b. Have you flown in the Civil Air Patrol in the last 12 months or do you intend to do so in the next 2 years? ... <input type="checkbox"/> Yes <input type="checkbox"/> No c. Do you intend to change your present flying to commercial or military flying in the next 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If any of the above questions is answered "Yes", please give details in Remarks below.)
SECTION 7 AVIATION RATES	Should you not qualify for full coverage at standard rates, do you desire: a. Full coverage with extra premium, if available? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Restricted aviation coverage without extra premium, if available? <input type="checkbox"/> Yes <input type="checkbox"/> No
REMARKS:	

The above statements and answers are complete and true to the best of my knowledge and belief and will be the basis for and a part of any policy issued based on them.

Signed at: _____ (X) _____
City and State Signature of Proposed Insured

Date: _____