

Producer Information:

Name: _____ Email: _____ Phone: _____ Fax: _____

Date/ Time Quote needed: _____

Insured information:

Name: _____ DOB: _____ Male: Female

Height: _____ Weight: _____ Blood Pressure: _____ Cholesterol: _____

License number: _____ License expiration: _____

Current coverage in force: Life Disability Long term care Annuity

Insured Medical information:

Did your father, mother or siblings have or die of cardiovascular disease, cancer or diabetes before the age of 60?

Yes No *If yes indicate which parent, sibling, condition, age of onset, cause of death and age at death*

Have you ever had cancer or any type of cardiovascular disease or issue?

Yes No *If yes provide details- dates, treatment and outcome*

Are you currently taking any prescription medication?

Yes No *If yes list name, dosage and purpose of medication*

Have you been treated for any illness/ injury or had any specialized test in the past 10 years?

Yes No *If yes provide details- dates, reason, and outcome*

In the past 3 years have you had any moving violations? Had your driver's license suspended or had a DUI in the past 5 years?

Yes No *If yes provide dates and details*

Have you or will you be traveling outside the US in the next 24 months?

Yes No *If yes provide details*

Insured medical information continued:

1. Heart conditions: Coronary artery, valve, heart muscle, high blood pressure, rhythm disorders? Yes No
2. Nicotine Use: Currently using- Type _____ Formally used- Type _____ - Date quite _____ Never used
3. Peripheral vascular disease: Carotid artery stenosis, blockage of leg arteries? Aneurysms, other? Yes No
4. Cancer or Tumors: Organ involved: _____ Tumor type: _____ Stage/Grade: _____ Not applicable
5. Mental health disorders: anxiety, depression, ADHD, bipolar, panic disorders, PTSD, other? Yes No
6. Lung disorders: asthma, sleep apnea, chronic bronchitis, emphysema, sarcoidosis, pulmonary fibrosis, other? Yes No
7. Brain disorders: stroke, TIA, multiple sclerosis, seizures, dementia, neuropathy, global amnesia, other? Yes No
8. Diabetes: Type-I Type-II Treatment _____ Diagnosis date: _____ Largest HgA1c _____ Not applicable
9. Muscles disorders: myasthenia Gravis, muscular dystrophy, polymyositis, dermatomycosis's, other?
10. Blood disorders: Anemia-type _____ clotting disorders-type _____ other? _____ Not applicable
11. Rheumatoid arthritis, Grave's disease, thyroiditis? Yes No
12. Systematic lupus, Ankylosing spondylitis, chronic fatigue syndrome? Yes No
13. Kidney inflammation, protein or microalbumin in urine? Pituitary disorders, Adrenal disorders? Other? Yes No
14. Liver disorders- hepatitis, fatty liver, abnormal liver function tests, other? Pancreatitis? Other? Yes No
15. Diverticulosis, weight-loss surgery, esophageal disorders, GERD, ulcerative colitis, Crohn's disease, other? Yes No
16. Arteritis, vasculitis, chronic pain syndrome, bone or joint disorders, ear, nose and throat disorders? Yes No
17. Substance use: Type: _____ date of any rehabilitation: _____ Relapse date: _____ Not applicable
18. Any condition not listed?

Please explain any information to which you answered yes or to which more information should be provided

Policy request information:

Plan desired: 10 yr. 15 yr. 20 yr. 25 yr. 30 yr. 35 yr. 40 yr.

Universal Life Index UL Whole Life Other

Death Benefit _____ State _____ Riders _____

Purpose of coverage: Family needs Business needs Estate needs Loans