

INFORMAL INQUIRY

Not an application for life insurance



Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

PRODUCER INFORMATION

Producer: _____ Date: _____
Face Amount: _____ Product: _____

PROPOSED INSURED INFORMATION

Applicant Name: _____ Male Female DOB: _____
SS#: _____ Drivers License #: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Home Work Mobile
Alternate Phone Number : _____ Home Work Mobile
Occupation: _____ Income: _____
Assets: _____ Liabilities: _____ Net Worth: _____
Premium Tolerance/Offer needed to place: _____
Can you provide Third Party Financials signed by a currently licensed CPA? Yes No

INSURANCE CURRENTLY IN FORCE

Company	Year Issued	Face Amount	Being Replaced?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

ACTIVITY AND MEDICAL INFORMATION

Do you participate in any hazardous activities? Flying Scuba Climbing Other
Details: _____

Do you have any plans for foreign travel? Yes No
Details: _____

Have you ever used any kind of tobacco product? Yes No
Forms Used: Cigarette Pipe Gum Patch Cigar Other
Frequency: Daily Weekly Monthly Other
Date last used: _____

Do you have any knowledge that an application or informal inquiry has been seen by any carrier in the last year?

Yes No

Company	Offer	Placed?

Height: _____ Weight: _____

ACTIVITY AND MEDICAL INFORMATION, CONTINUED

Do you have a history of:

High Blood Pressure Yes No

Heart Condition/Coronary Artery Disease Yes No

Heart Attack Bypass Surgery Date of event: _____

Stent(s) Date of Last EKG/Stress Test: _____

Diabetes Yes No

At what age were you diagnosed? _____

List all diabetes medications currently prescribed:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Most recent A1c level: _____ Current glucose reading: _____

Respiratory Disease Yes No

Have you been hospitalized for this condition? Yes No

Have you been diagnosed with sleep apnea? Yes No

Are you currently using a CPAP? Yes No

Date of last pulmonary function test: _____

Cancer Yes No

Type of cancer: _____

Was there a biopsy? Yes No Cancer stage if known: _____

Date of surgery, if any? _____

Date of completion of radiation treatment: _____

Date of completion of chemotherapy: _____

Please list any medical conditions not indicated above: _____

FAMILY MEDICAL HISTORY

Family Member	Age If deceased, age @ death and cause	History of Heart Disease?		History of Cancer?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mother		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Father		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sibling 1		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sibling 2		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SENIOR SUPPLEMENT

Have you been diagnosed with Alzheimer's or dementia? Yes No

Have you ever been treated for memory problems? Yes No

Do you require assistance for walking? Yes No

Do you have a history of falls? Yes No

Do you exercise on a daily basis? Yes No

Do you require assistance with daily chores? Yes No

Do you drink alcohol? Yes No

Have you ever been diagnosed with depression? Yes No

Have you ever been diagnosed with anemia? Yes No

Please provide details of any "Yes" answers above: _____

