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?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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?	Type
Mother		☐ Yes	☐ No	☐ Yes	☐ No
Father		☐ Yes	☐ No	☐ Yes	☐ No
Sibling 1		☐ Yes	☐ No	☐ Yes	☐ No
Sibling 2		☐ Yes	☐ No	☐ Yes	☐ 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: _____

SENIOR SUPPLEMENT, CONTINUED

Please list all medications being taken: _____

_____

PHYSICIAN INFORMATION

Physician Name: _____ Phone: _____

Address: _____

Date last seen: _____ Reason: _____

Physician Name: _____ Phone: _____

Address: _____

Date last seen: _____ Reason: _____

PHYSICIAN INFORMATION, CONTINUED

Physician Name: _____ Phone: _____

Address: _____

Date last seen: _____ Reason: _____

Physician Name: _____ Phone: _____

Address: _____

Date last seen: _____ Reason: _____

ADDITIONAL NOTES