

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

Table with 4 columns: Company, Year Issued, Face Amount, Being Replaced? (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
Table with 3 columns: 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	History of Heart Disease?		History of Cancer?	
	If deceased, age @ death and cause	☐ Yes	☐ No	☐ Yes	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

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.