FFS Impaired Risk Quote Form

Send completed form to the FFS Sales Department at Sales@FirstFinancialSecurity.com or 404.806.2326 (Fax).

Agent Information

Agent Name: _____ **FFS Code #:** _____

Email Address: _____ Phone Number: _____

Proposed Insured - Personal Information

Name: _____ **Gender:** ☐ Male ☐ Female

Date of Birth: _____ **Age:** _____ **Height:** _____ (ft/in) **Weight:** _____ (lbs)

State of Issue: _____ **Speaks English:** ☐ Yes ☐ No >> List Language _____

Have you had any motor-vehicle related incidents in the past 10 years?
☐ Yes ☐ No

If yes, give details and dates:

_____

Proposed Insured - Policy Information

1. **Type of Insurance Coverage Requested:** ☐ Term ☐ Whole Life ☐ IUL ☐ Final Expense

2. **Amount of Insurance Being Applied For:** _____ **Anticipated Premium:** _____

2a. **Premium Mode:** ☐ Monthly Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual

3. **Have you had previous applications for insurance denied or postponed (through FFS or other carriers)?**
☐ Yes >> Go to Q.3a ☐ No >> Skip to "Health History"

3a. **If yes, provide details (carrier, policy number, amount, denial reason, etc.…):**

_____

Proposed Insured - Health History

4. **Current Nicotine Use:** ☐ None ☐ Cigarettes ☐ Other **Daily Amount:** _____

4a **If you have used nicotine in the past, please list each type of tobacco, quantity and frequency used and date of last use** _____

5. **Are you currently taking medication for blood pressure (BP)?**
☐ Yes >> Go to Q.5a ☐ No

5a. **Name of BP medication and dosage:** _____

6. **Are you currently taking medication for cholesterol?**
☐ Yes >> Go to Q.6a ☐ No

6a. **Name of cholesterol medication and dosage:** _____

FFS First Financial Security, Inc.

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7. **Have you ever had, been told you have, or been treated for any of the conditions below? Check all that apply:**

- ☐ Alcohol or Drug Abuse
- ☐ Alzheimer's/Dementia/Cognitive Impairment
- ☐ Asthma
- ☐ Cancer
- ☐ Cirrhosis
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Murmur/Valve Disease
- ☐ Hepatitis
- ☐ Irregular Heartbeat/Palpitations
- ☐ Kidney Disease
- ☐ Lupus/Multiple Sclerosis
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Other

7a. **For any condition checked above, list dates, diagnoses, details, and treatment:**

_____

7b. **Current Medications (list all medication and dosage not already disclosed on form):**

_____

Proposed Insured - Family History

8. **To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60, due to cardiovascular disease, diabetes, or cancer?**

☐ Yes >> Go to Q.8a ☐ No

8a. **If yes, provide full details with impairment, age at onset and age at death if deceased**.

Father: _____

Mother: _____

Sibling: _____

Additional Notes:

_____

Proposed Insured - Citizenship and Travel

9. **Are you a US citizen?** ☐ Yes ☐ No >> list type of visa, green card status & length of time in US

_____

10. **Do you have any future plans to live or travel outside the US?**

☐ Yes >> Go to Q.10a ☐ No

10a. **If yes, (provide purpose, cities, countries, frequency, & duration):**

_____