

QUICK QUOTE FOR BUILD

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

FAMILY HISTORY –
 AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS _____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____ / ARE YOU TREATED FOR BLOOD PRESSURE? NO YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____ / ARE YOU TREATED FOR CHOLESTEROL? NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. MEDICAL HISTORY DETAILS (CHECK ALL THAT APPLY):

HEART HISTORY / CONDITION
 DIABETES HISTORY
 HIGH BLOOD PRESSURE
 CHOLESTEROL
 SLEEP APNEA

2. PROVIDE THE FOLLOWING REGARDING BLOOD PRESSURE HISTORY:

CURRENT BP READING _____

HIGHEST BP READING _____

ANY TREATMENT? IF YES, DETAILS _____

3. PROVIDE THE FOLLOWING REGARDING CHOLESTEROL HISTORY:

CURRENT READING _____

HDL READING OR CHOL/HDL RATIO _____

HIGHEST CHOLESTEROL READING _____

ANY TREATMENT? IF YES, DETAILS _____

4. HEIGHT _____ WEIGHT _____

WEIGHT LOSS IN LAST YEAR _____

LAST MEASURED BODY FAT % _____ / DATE _____

5. MEN ONLY: CHEST SIZE _____ IN. / WAIST SIZE _____ IN.

6. HAS A STANDARD MEDICAL CHECK-UP BEEN COMPLETED WITHIN THE PAST YEAR:

NO YES, PLEASE PROVIDE:

DATE _____ RESULTS; _____

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):
