QUICK QUOTE FOR BUILD

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

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 GIVE RELATION, AGE AND CAUSE, OF EACH ______________________

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 __________ / DATE OF LAST EKG __________ AND RESULTS ______________

LAST BLOOD PRESSURE READING (RESULTS) __________/__________ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) __________, __________ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME ______________________ PHONE ______________ FAX ______________

ADDRESS ______________________ CITY ______________ ST _____ ZIP _________

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION ______________________ FAX ______________

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1. DETAIL THE CLIENT'S MEDICAL HISTORY (CHECK ALL THAT APPLY):

❑ CANCER HISTORY
❑ HEART HISTORY / CONDITION
❑ DIABETES HISTORY
❑ ALCOHOL OR DRUG ABUSE HISTORY
❑ HIGH BLOOD PRESSURE, PLEASE DETAIL:

CURRENT READING ________ / HIGHEST READING ________

TYPE OF TREATMENT ______________________

❑ ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING ______ / HDL READING OR RATIO _______

HIGHEST CHOLESTEROL READING ______________

TYPE OF TREATMENT ______________________

2. HT _____ WT _____ / WT LOSS IN LAST YEAR __________

LAST MEASURED BODY FAT % _______ / DATE __________

MEN ONLY: CHEST SIZE _______ IN. / WAIST SIZE _______ IN.

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP W/IN THE PAST YEAR:

❑ NO ❑ YES, PLEASE DETAIL: ❑ NORMAL ❑ OTHER _______

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

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