

Informal Inquiry

(Not An Application For Life Insurance)



1500 State Street, Suite #220
San Diego, CA 92101
(619) 220-8116

Date: _____ Producer: _____ Face Amount: _____ Product Type: _____

Applicant: _____ Male Female DOB: _____

SS#: _____ - _____ Driver's License #: _____ Place of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Occupation: _____ How Long: _____

Income: _____ Assets: _____ Liabilities: _____ Net Worth: _____

Premium Tolerance/Offer needed to place: _____

Has the Owner/Insured ever sold an insurance policy? No Yes If yes, when? _____

Will this case be premium financed? No Yes If yes, program considered? _____

Can you provide 3rd party financials signed by a currently licensed CPA? No Yes

Insurance Currently In Force:

Company _____ Year Issued _____ Face Amount _____

Replace? _____ Offer to be Replaced _____

Company _____ Year Issued _____ Face Amount _____

Replace? _____ Offer to be Replaced _____

Company _____ Year Issued _____ Face Amount _____

Replace? _____ Offer to be Replaced _____

Do you participate in any hazardous activities? Flying Scuba Diving Mountain Climbing Other _____

Do you have any plans for foreign travel? No Yes (If yes, please advise when, where, purpose and how long): _____

Have you ever used any kind of tobacco or any other products containing nicotine? Yes No

If yes, please indicate which form: cigarette pipe nicotine gum/patch cigar (how many per year) ? _____

other _____ Has use been discontinued? No Yes Date discontinued: _____

Do you have any knowledge that an application or informal inquiry has been seen by any carriers within the last year?

Yes No

Carrier _____ Offer _____ Decline

Carrier _____ Offer _____ Decline

Carrier _____ Offer _____ Decline

Height: _____ Weight: _____

Do you have a history of:

High Blood Pressure? No Yes What medications were you taking? _____

Heart condition/Coronary Artery Disease? No Yes When did the event occur? _____

Heart Attack Bypass Stent(s) How many Vessel's affected? _____ Last EKG/Stress Test? _____

Name and address of physicians that treat you: _____

Diabetes? No Yes, Type1 Type2 At what age were you first diagnosed? _____

List medications being taken: _____ Last A1C numbers? _____

Last Glucose readings? _____

What is the therapy and doses at present time? _____

Check box for any complications: Kidneys Peripheral vascular disease Neuropathy Retinopathy

Name and address of physicians that treat you: _____

Respiratory Disease? No Yes Check appropriate box: Asthma COPD

Have you ever been hospitalized? No Yes Have you ever been diagnosed with Sleep Apnea? No Yes

Currently using CPAP? No Yes Date: _____ Last Pulmonary Function Test? _____

Name and address of physicians that treat you: _____

Arthritis? No Yes Type? _____

Name and address of physicians that treat you: _____

Cerebral Vascular Accident? No Yes Type of Event: Stroke TIA Date of Event: _____

Name and address of physicians that treat you: _____

Cancer? No Yes _____

When/where were you diagnosed with cancer? _____

What physicians would have the pathology report? _____

Was there a biopsy? No Yes What is the stage of the cancer? _____

What are the dates of radiation or chemotherapy? _____

Name and address of physicians that treat you: _____

Family Health History:

Relationship	Age (If deceased, age at death)	History of Heart Disease	History of Cancer (All Types)
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<input type="checkbox"/> Mother	_____	_____	_____
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<input type="checkbox"/> Father	_____	_____	_____
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<input type="checkbox"/> Sister(s)	_____	_____	_____
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<input type="checkbox"/> Brother(s)	_____	_____	_____
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List any medical conditions not indicated above: _____

Senior Supplement 70+

Have you ever been diagnosed with Alzheimers or Dementia? No Yes

Have you ever been tested for memory problems? No Yes

What medications are you currently on? _____

Do you require assistive devices for walking? No Yes Do you have a history of falls? No Yes

If so, please explain: _____

Do you require assistance with daily chores? No Yes Do you drink alcohol? No Yes

Have you ever been diagnosed with depression? No Yes Have you ever been diagnosed with anemia? No Yes

Details: _____

Physician Information: Please list all physicians seen within the past ten (10) years:

Physician Name: _____ Phone: () _____

Address: _____

Date Last Seen: _____ Reason: _____

Physician Name: _____ Phone: () _____

Address: _____

Date Last Seen: _____ Reason: _____

(Please use an additional page, if necessary.)