

QUICK QUOTE Other Illnesses



Phoenix, AZ 85049-0187
Phone: 602-494-9500/800-516-0283
FAX: 602-494-0500
Email: info@lbiusa.com

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. © COPYRIGHT LifeBrokers.

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 _____

1. PLEASE LIST ILLNESS(ES) AND DETAILS – INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE AND/OR AMOUNT OF TREATMENT ON EACH):

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER:

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER:

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER:

2. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

- 0 TO 6 MONTHS AGO
 6 TO 12 MONTHS AGO
 12 TO 24 MONTHS AGO
 OVER 2 YEARS AGO

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

