

Brokerage Concepts, Inc.  
Quick Quote Form

Please fax completed form to:

(610)878-9614

to the attention of:

Life Brokerage Manager

# BROKERAGE CONCEPTS, INC. - QUOTE FOR ALCOHOL AND DRUG USAGE

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE NOTE CLIENT'S CONDITION:

[ ] ALCOHOL ABUSE (ANSWER Q'S 2 - 7)

[ ] DRUG ABUSE (ANSWER Q'S 8 - 10)

2. DOES THE CLIENT CURRENTLY CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

[ ] NO [ ] YES, HOW OFTEN AND IN WHAT AMOUNTS:

\_\_\_\_\_

3. IS THE CLIENT CURRENTLY A MEMBER OF AA OR A SIMILAR SUPPORT GROUP?

[ ] NO [ ] YES

4. HAS THE CLIENT EVER BEEN HOSPITALIZED, INSTITUTIONALIZED, OR BEEN AN OUTPATIENT IN AN ALCOHOL REHABILITATION PROGRAM?

[ ] NO [ ] YES, DATE OF DISCHARGE: \_\_\_\_\_

5. WITHIN THE LAST 10 YEARS, LIST THE DATE(S) OF DRIVING UNDER THE INFLUENCE (DUI) ARRESTS AND CONVICTIONS OR CHECK NONE [ ]

\_\_\_\_\_

6. RESULTS OF THE MOST RECENT LIVER FUNCTION TESTS:

[ ] NORMAL

[ ] MINIMALLY ELEVATED

[ ] MODERATELY ELEVATED

[ ] ELEVATED

7. IS THE CLIENT PRESENTLY TAKING, OR TAKEN IN THE PAST, ANTABUSE OR ANOTHER MEDICATION TO HELP CONTROL DRINKING?

[ ] NO [ ] YES

8. IS THE CLIENT USING, OR USED IN THE PAST, ANY OF THE FOLLOWING SUBSTANCES OR DRUGS (CHECK BOX AND DETAIL)

[ ] OPIATES/NARCOTICS: HEROIN, CODEINE, MORPHINE, METHODONE, DEMOROL

[ ] BARBITURATES: AMYTAL, PHENOBARBITAL

[ ] NON-BARBITURATES: PLACIDYL, DORIDEN, QUAALUDE

[ ] AMPHETAMINES: BENZEDRINE, DEXEDRINE

[ ] METHAMPHETAMINE: COCAINE, CRACK, ICE

[ ] HALLUCINOGENS: LSD, PEYOTE, PSILOCYBIN, ECSTASY

[ ] MARIJUANA

[ ] OTHER: \_\_\_\_\_

DETAIL DATE LAST USED, AMOUNT, FREQUENCY: \_\_\_\_\_

\_\_\_\_\_

9. HAS THE CLIENT EVER BEEN TREATED FOR SUBSTANCE ABUSE?

[ ] NO [ ] YES, DETAIL DATE(S), PLACE(S):

\_\_\_\_\_

10. HAS THE CLIENT EVER BEEN ARRESTED FOR POSSESSION, USE, DISTRIBUTION OF, OR SALE OF AN ILLEGAL SUBSTANCE?

[ ] NO [ ] YES, DETAIL DATE(S), PLACE(S):

\_\_\_\_\_

11. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_

\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR BUILD

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
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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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
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LAI 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 AND DATE \_\_\_\_\_

TYPE OF TREATMENT \_\_\_\_\_

[ ] ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING \_\_\_\_\_

HDL READING OR RATIO \_\_\_\_\_

HIGHEST CHOL. READING \_\_\_\_\_

TYPE OF TREATMENT \_\_\_\_\_

[ ] ELECTROCARDIOGRAM (EKG), IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] STRESS EKG OR THALLIUM, IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] SIGMOIDOSCOPY, IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] PROSTATE EXAM, IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] MAMMOGRAM, IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

2. HEIGHT \_\_\_\_\_ / WEIGHT \_\_\_\_\_

WEIGHT LOSS IN LAST YEAR \_\_\_\_\_

LAST MEASURED BODY FAT % \_\_\_\_\_ DATE \_\_\_\_\_

MEN ONLY: CHEST SIZE \_\_\_\_\_ INCHES

WAIST SIZE \_\_\_\_\_ INCHES

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP WITHIN THE PAST YEAR?

[ ] NO [ ] YES, PLEASE DETAIL RESULTS:

[ ] NORMAL [ ] OTHER \_\_\_\_\_

4. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR CANCER

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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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
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1. TYPE OF MALIGNANCY OR CANCER?  
[ ] BLADDER  
[ ] BREAST  
[ ] CERVICAL  
[ ] COLON OR RECTAL (ALSO COMPLETE QUESTION #4)  
[ ] HODGKIN'S DISEASE  
[ ] MELANOMA (ALSO COMPLETE QUESTION #5)  
[ ] PROSTATE (ALSO COMPLETE QUESTION #9)  
[ ] SKIN (ALSO COMPLETE QUESTION #5)  
[ ] OTHER \_\_\_\_\_

2. HAS TUMOR OR MALIGNANCY METASTASIZED?  
[ ] YES [ ] NO, PLEASE DETAIL:  
DATE DIAGNOSED: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

3. STAGE OF TUMOR OR MALIGNANCY: T \_\_\_ N \_\_\_ M \_\_\_  
OR [ ] 1 [ ] 2 [ ] 2A [ ] 2B [ ] 3 [ ] 3A [ ] 3B [ ] 4 [ ] 5  
[ ] OTHER \_\_\_\_\_

4. DUKE'S SCALE (FOR COLON OR RECTAL CANCER ONLY):  
[ ] A1 [ ] B1 [ ] B2 [ ] C1 [ ] C2 [ ] D

5. CLARK'S LEVEL (FOR MELANOMA ONLY):  
[ ] I [ ] II [ ] III [ ] IV [ ] V  
TYPE \_\_\_\_\_  
LOCATION ON BODY \_\_\_\_\_  
DEPTH OF MELANOMA \_\_\_\_\_

6. TYPES OF TREATMENT USED (CHECK ALL APPLICABLE):  
[ ] SURGICAL REMOVAL OF MALIGNANCY  
[ ] CHEMOTHERAPY  
[ ] RADIATION THERAPY  
[ ] HORMONAL (ORCHIDECTOMY - DES. LUPRON)  
[ ] OTHER \_\_\_\_\_

7. DATE OF LAST TREATMENT RECEIVED \_\_\_\_\_

8. HAS THERE BEEN ANY MEDICAL EVIDENCE OF RECURRENT CANCER?  
[ ] NO [ ] YES, PLEASE DETAIL DATE AND OCCURRENCE  
\_\_\_\_\_

9. (FOR PROSTATE CANCER ONLY):  
STAGE: T \_\_\_ N \_\_\_ M \_\_\_  
OR [ ] A1 [ ] A2 [ ] B1 [ ] B2 [ ] C1 [ ] C2 [ ] D  
GLEASON'S GRADE: [ ] 2 OR 3 [ ] 4 OR 5 [ ] 6 OR MORE  
RESULTS OF MOST RECENT PSA TEST \_\_\_\_\_

10. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR CEREBROVASCULAR ACCIDENT (STROKE)

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. THE DATE OF CLIENT'S FIRST STROKE:

MONTH \_\_\_\_\_ / YEAR \_\_\_\_\_

2. THE DATE OF CLIENT'S LAST STROKE:

MONTH \_\_\_\_\_ / YEAR \_\_\_\_\_

3. NUMBER OF STROKES SUFFERED DURING THE LAST 24 MONTHS:

- [ ] NONE
- [ ] ONE
- [ ] TWO OR MORE

4. HAS THE CLIENT EVER HAD CAROTID ARTERY SURGERY AS THE RESULT OF A STROKE?

[ ] NO [ ] YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ / YEAR \_\_\_\_\_

5. AS A RESULT OF STROKE, DOES THE CLIENT HAVE ANY RESIDUAL NEUROLOGICAL DEFICITS, SUCH AS: SLURRED SPEECH, LOSS OF USE OR RESTRICTED LIMB MOVEMENT, OR ANY OTHER IMPAIRMENT?

[ ] NO [ ] YES, PLEASE DETAIL:

\_\_\_\_\_  
\_\_\_\_\_

6. APPROXIMATE DATE OF THE LAST STRESS EKG:

- [ ] WITHIN THE LAST 6 MONTHS
- [ ] 6 MONTHS TO A YEAR AGO
- [ ] MORE THAN A YEAR AGO

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - CPS QUICK QUOTE FOR CHRONIC LYMPHOCYTIC LEUKEMIA

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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DO YOU EXERCISE 3 OR MORE TIMES PER WEEK [ ] NO [ ] YES, DETAILS \_\_\_\_\_  
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LAST BLOOD PRESSURE READING (RESULTS) \_\_\_\_\_ / \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE [ ] NO [ ] YES  
LAST CHOLESTEROL READING, HDL READING (RESULTS) \_\_\_\_\_, \_\_\_\_\_ TREATED FOR CHOLESTEROL [ ] NO [ ] YES  
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1. PLEASE LIST DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. PLEASE NOTE CURRENT STAGE OF THE LEUKEMIA

- [ ] STAGE 0
- [ ] STAGE 1
- [ ] STAGE 2
- [ ] STAGE 3
- [ ] STAGE 4

3. IS THE CLIENT ON ANY MEDICATIONS FOR THIS DISEASE?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

\_\_\_\_\_

4. PLEASE PROVIDE RESULTS OF MOST RECENT CBC (COMPLETE BLOOD COUNT):

DATE \_\_\_\_\_

HEMOGLOBIN \_\_\_\_\_

WHITE BLOOD CELL COUNT \_\_\_\_\_

PLATELET COUNT \_\_\_\_\_

5. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR ULCERATIVE COLITIS (CROHN'S DISEASE)

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
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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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
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LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE NOTE TYPE OF INFLAMMATORY BOWEL DISEASE PRESENT:

- CHRONIC ULCERATIVE COLITIS
- CHRONIC PROCTITIS
- CROHN'S DISEASE

2. PLEASE LIST DATE OF ONSET \_\_\_\_\_

3. PLEASE NOTE SEVERITY:

- MILD (UP TO 4 WEEKS DURATION, MAXIMUM 1 ATTACK PER YEAR)
- MODERATE (4 TO 6 WEEKS DURATION, 2 ATTACKS PER YEAR)
- SEVERE (OVER 6 WEEKS DURATION, 3 OR MORE ATTACKS PER YEAR)

4. PLEASE NOTE LOCATION(S) OF ULCERATIVE COLITIS:

- LARGE COLON
- SMALL BOWEL
- RECTUM ONLY (PROCTITIS)

5. PLEASE DETAIL TREATMENT INVOLVED (CHECK AND DETAIL FOR ALL THAT APPLY):

- MEDICATION, TYPE AND DOSAGE \_\_\_\_\_
- SURGERY
- RESECTION WITH TOTAL COLECTOMY, DATE \_\_\_\_\_
- RESECTION WITH PARTIAL COLECTOMY, DATE \_\_\_\_\_
- HOSPITALIZATION, DATE \_\_\_\_\_

6. PLEASE NOTE ALL OTHER RELATED COMPLICATIONS OR IMPAIRMENTS (CHECK ALL THAT APPLY):

- LIVER DISORDER OR ELEVATED LIVER FUNCTION TESTS
- ANEMIA
- GASTROINTESTINAL BLEEDING
- TRANSFUSIONS
- ARTHRITIS

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR CORONARY ANGIOPLASTY AND BYPASS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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## 1. WHICH OF THE FOLLOWING PROCEDURES WAS DONE?

- CORONARY BYPASS
- ANGIOPLASTY (GO TO QUESTION #6)

## 2. WHEN WAS BYPASS SURGERY PERFORMED?

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

IF A SECOND BYPASS WAS PERFORMED:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

## 3. AGE WHEN BYPASS SURGERY WAS PERFORMED \_\_\_\_\_

## 4. HOW MANY GRAFTS WERE PERFORMED?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 OR MORE

## 5. INDICATE THE TYPE OF GRAFT(S) USED:

- SAPHENOUS VEIN (FROM LEGS)
- INTERNAL MAMMARY ARTERY
- BOTH

IF THERE WAS ANGIOPLASTY DONE IN ADDITION TO BYPASS SURGERY, PLEASE CONTINUE WITH QUESTION 6, IF NOT GO TO QUESTION 8.

## 6. WHEN WAS THE CORONARY ANGIOPLASTY PERFORMED?

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

IF A SECOND ANGIOPLASTY WAS PERFORMED:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

## 7. HOW MANY ARTERIES WAS THE PROCEDURE PERFORMED ON:

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 OR MORE

## 8. WHICH CONDITIONS PRECEDED THE ANGIOPLASTY OR BYPASS?

- HEART ATTACK
- CHEST PAIN
- IRREGULAR STRESS EKG
- EXTREME FATIGUE
- OTHER \_\_\_\_\_

## 9. SINCE THE TIME OF THE ANGIOPLASTY OR BYPASS, HAS THE CLIENT EXPERIENCED EITHER OF THE FOLLOWING:

- CHEST PAIN
- IRREGULAR STRESS EKG

## 10. APPROXIMATE DATE OF THE LAST EKG:

- WITHIN THE LAST 6 MONTHS
- 6 MONTHS TO A YEAR AGO
- MORE THAN A YEAR AGO

## 11. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR DEPRESSION

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

---

1. CLIENT HAS BEEN DIAGNOSED AS:

- [ ] HAVING DEPRESSION
- [ ] BEING MANIC DEPRESSIVE (BIPOLAR)

2. HAS THE CLIENT EVER ATTEMPTED SUICIDE?

[ ] NO [ ] YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

3. HAS CLIENT EVER BEEN HOSPITALIZED FOR DEPRESSION?

[ ] NO [ ] YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

4. DURING THE PAST 12 MONTHS, HAS THE CLIENT MISSED WORK DUE TO DEPRESSION?

[ ] NO [ ] YES, PLEASE DETAIL NUMBER OF OCCASIONS AND AMOUNT OF TIME MISSED:

\_\_\_\_\_

5. IS THE CLIENT CURRENTLY TAKING MEDICATION FOR DEPRESSION?

[ ] NO [ ] YES, PLEASE DETAIL TYPE AND DOSAGE:

\_\_\_\_\_

\_\_\_\_\_

6. IS THE CLIENT CURRENTLY SEEING OR HAS HE/SHE SEEN A MENTAL HEALTH THERAPIST?

[ ] YES [ ] NOT CURRENTLY [ ] NO

IF YES, OR NOT CURRENTLY, PLEASE DETAIL HOW OFTEN, FOR HOW LONG, AND THE DATE OF THE LAST VISIT:

\_\_\_\_\_

\_\_\_\_\_

7. IS THE CLIENT CURRENTLY RECEIVING, OR IN THE PAST RECEIVED, DISABILITY BENEFITS DUE TO DEPRESSION OR OTHER DISABILITY?

[ ] NO [ ] YES, PLEASE DETAIL START AND END DATES:

START: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

END: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

[ ] YES, CLIENT IS STILL GETTING BENEFITS

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR DIABETES

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. CLIENT'S AGE AT ONSET OF DIABETES \_\_\_\_\_

2. WHAT IS THE METHOD OF CONTROL?

- DIET ONLY
- DIET AND ORAL MEDICATION(S)\*
- DIET AND INSULIN INJECTION

\*LIST MEDICATIONS: \_\_\_\_\_

3. HOW MANY TIMES A DAY IS INSULIN ADMINISTERED?

- ONE OR TWO TIMES PER DAY
- THREE OR MORE TIMES PER DAY
- INSULIN PUMP

4. HOW OFTEN ARE BLOOD SUGAR LEVELS MONITORED?

- ONE OR TWO TIMES PER DAY
- THREE OR MORE TIMES PER DAY

5. PLEASE INDICATE ANY OF THE FOLLOWING EXPERIENCED:

- EKG ABNORMALITIES
- INSULIN REACTIONS
- DIABETIC COMA
- EYE TROUBLE
- HEART TROUBLE
- PROTEIN IN URINE
- SKIN ULCERATION
- AMPUTATIONS
- NEUROPATHY OR LOSS OF FEELING

6. PLEASE DETAIL ANY INDICATIONS FROM QUESTION #5, SUCH AS: TYPE OF; DATE OF; FREQUENCY OF OCCURRENCE:

\_\_\_\_\_  
\_\_\_\_\_

7. HAS THE CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?

[ ] NO [ ] YES, PLEASE DETAIL LEVEL:

- BELOW 7.5
- 7.6 TO 10
- 10.1 TO 13
- ABOVE 13

8. HOW LONG HAS THE GLYCOHEMOGLOBIN LEVEL REMAINED CONSTANT?

- 0 TO 6 MONTHS
- 6 TO 12 MONTHS
- OVER A YEAR

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

- 0 TO 6 MONTHS AGO
- 6 TO 12 MONTHS AGO
- OVER 1 YEAR AGO

10. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR DRIVING VIOLATIONS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

---

1. LIST ALL MOVING MOTOR VEHICLE AND SPEEDING VIOLATIONS OVER THE PAST FIVE YEARS:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

DETAIL \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

2. DOES THE CLIENT CURRENTLY HOLD A VALID DRIVER'S LICENSE?

[ ] NO [ ] YES PLEASE DETAIL:

STATE \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

3. DETAIL LAST MOVING VIOLATIONS OTHER THAN SPEEDING, IF ANY:

TYPE \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
TYPE \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

[ ] NONE

4. DETAIL ACCIDENTS INVOLVING MAJOR PROPERTY DAMAGE, IF ANY:

DETAIL \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

5. WITHIN THE LAST SIX YEARS, LIST THE OCCASION AND DATE OF DRIVING UNDER THE INFLUENCE (DUI) ARRESTS AND CONVICTIONS:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

[ ] NONE

6. HAS THE CLIENT EVER BEEN TREATED FOR SUBSTANCE ABUSE?

[ ] NO [ ] YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
PLACE \_\_\_\_\_

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR HEART ATTACK (MYOCARDIAL INFARCTION)

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

---

1. LIST DATES OF HEART ATTACKS AND SEVERITY OF EACH:

DATE \_\_\_\_\_ [ ] MILD [ ] MODERATE [ ] SEVERE  
TIME UNTIL RETURN TO NORMAL ACTIVITIES? \_\_\_\_\_  
DATE \_\_\_\_\_ [ ] MILD [ ] MODERATE [ ] SEVERE  
TIME UNTIL RETURN TO NORMAL ACTIVITIES? \_\_\_\_\_

2. WHAT CONDITION(S) PRECEDED THE HEART ATTACK(S)?

[ ] CHEST PAIN  
[ ] ARRHYTHMIA OR IRREGULAR HEART BEATS  
[ ] IRREGULAR EKG  
[ ] IRREGULAR STRESS EKG  
[ ] OTHER \_\_\_\_\_

3. DOES CLIENT WORK FULL TIME? [ ] YES [ ] NO

4. ACTIVITIES CAPABLE OF PERFORMING (CHECK LEVEL OF EXERCISE THAT BEST APPLIES):

[ ] LEVEL ONE - HEAVY LABOR, HANDBALL, CROSS COUNTRY SKIING, RUNNING 10 MINUTE MILES, BICYCLING AT 12MPH  
[ ] LEVEL TWO - SHOVELING, WOOD CUTTING, CANOEING, JOGGING 12 MINUTE MILES, SWIMMING CRAWL STROKE, ROWING MACHINE  
[ ] LEVEL THREE - CARPENTRY, LAWN MOWING, SINGLES TENNIS, DOWNHILL SKIING, SWIMMING BREAST STROKE  
[ ] LEVEL FOUR - SEDENTARY LIFE STYLE (UNABLE TO DO ANY OF LEVELS ONE THROUGH THREE)

5. SINCE THE HEART ATTACK, HAS CLIENT EXPERIENCED ANY OF THE FOLLOWING?

[ ] CHEST PAINS OR ANGINA  
[ ] IRREGULAR EKG OR STRESS EKG  
[ ] ARRHYTHMIA  
[ ] CONGESTIVE HEART FAILURE

6. WHAT TREATMENT(S) HAVE BEEN PRESCRIBED?

DATE LAST CONSULTED PHYSICIAN \_\_\_\_\_ LIST ALL  
MEDICATIONS: \_\_\_\_\_  
[ ] ANGIOPLASTY OR [ ] BYPASS, DETAILS: \_\_\_\_\_  
DATE \_\_\_\_\_

NUMBER OF ARTERIES OR GRAFTS PERFORMED ON:

DATE \_\_\_\_\_  
OTHER TREATMENTS: \_\_\_\_\_

7. WHAT TESTS HAVE BEEN PERFORMED? (CHECK ALL THAT APPLY):

[ ] RESTING EKG / DATE \_\_\_\_\_ RESULTS \_\_\_\_\_  
[ ] EXERCISE EKG / DATE \_\_\_\_\_ RESULTS \_\_\_\_\_  
[ ] THALLIUM TEST / DATE \_\_\_\_\_ RESULTS \_\_\_\_\_  
[ ] STRESS ECHO / DATE \_\_\_\_\_ RESULTS \_\_\_\_\_  
[ ] CORONARY CATHETERIZATION  
DATE \_\_\_\_\_ RESULTS \_\_\_\_\_

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR HEART CONDITIONS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

---

## 1. THE CLIENT'S HEART CONDITION / DIAGNOSIS IS:

[ ] HEART MURMUR: TYPE \_\_\_\_\_ GRADE \_\_\_\_\_

[ ] CARDIOMYOPATHY:

TYPE:

[ ] CONGESTIVE

[ ] RESTRICTIVE

[ ] ASYMMETRIC SEPTAL HYPERTROPHY

[ ] IDIOPATHIC HYPERTROPHY SUB-AORTIC STENOSIS

[ ] CARDIAC ENLARGEMENT / LEFT VENTRICLE HYPERTROPHY

[ ] ARRHYTHMIAS:

TYPE \_\_\_\_\_

[ ] CONGESTIVE HEART FAILURE

[ ] CHEST PAINS

[ ] OTHER \_\_\_\_\_

2. DATE DIAGNOSED \_\_\_\_\_ DATE RESOLVED \_\_\_\_\_

## 3. ARE THERE ANY CURRENT SYMPTOMS?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 4. WHAT TREATMENTS HAVE BEEN PRESCRIBED?

[ ] MEDICATIONS, PLEASE LIST \_\_\_\_\_

[ ] PACEMAKER, START DATE \_\_\_\_\_

[ ] SURGERY, PLEASE DETAIL TYPE AND DATE \_\_\_\_\_

\_\_\_\_\_

## 5. DOES CLIENT WORK FULLTIME? [ ] YES [ ] NO

## 6. WHAT TESTS HAVE BEEN PERFORMED?

[ ] RESTING EKG

DATE AND RESULTS \_\_\_\_\_

[ ] EXERCISE EKG

DATE AND RESULTS \_\_\_\_\_

[ ] THALLIUM TEST

DATE AND RESULTS \_\_\_\_\_

[ ] STRESS ECHOCARDIOGRAM

DATE AND RESULTS \_\_\_\_\_

[ ] CORONARY CATHETERIZATION

DATE AND RESULTS \_\_\_\_\_

[ ] EJECTION FRACTION

DATE AND RESULTS \_\_\_\_\_

## 7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR HEPATITIS (ELEVATED LIVER FUNCTIONS)**

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. LIST DATE AND RESULTS OF THE CLIENT'S TWO MOST RECENT LIVER FUNCTION TESTS:

	RESULT	DATE#1	RESULT	DATE#2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. CHECK TYPE, THEN LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

- [ ] A DATE \_\_\_\_\_ [ ] NEG [ ] POS
- [ ] B DATE \_\_\_\_\_ [ ] NEG [ ] POS
- [ ] C DATE \_\_\_\_\_ [ ] NEG [ ] POS

3. HAS THE CLIENT HAD A LIVER BIOPSY?

[ ] NO [ ] YES, PLEASE DETAIL DATE AND RESULTS:

\_\_\_\_\_

\_\_\_\_\_

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH:

FATTY LIVER? [ ] NO [ ] YES, PLEASE DETAIL:

\_\_\_\_\_

HEPATITIS? [ ] NO [ ] YES, CHECK TYPE, THEN DETAIL:

[ ] ACUTE [ ] CHRONIC ACTIVE [ ] CHRONIC PERSISTENT  
 DETAILS: \_\_\_\_\_

CIRRHOSIS? [ ] YES [ ] NO

5. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

[ ] NO [ ] YES, PLEASE DETAIL FREQUENCY AND AMOUNT:

\_\_\_\_\_

IF NO, DATE OF LAST DRINK: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

6. 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

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR HYPERTENSION (HIGH BLOOD PRESSURE)**

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_
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 \_\_\_\_\_
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. PLEASE DETAIL THE CLIENT'S FAMILY HISTORY: (AGE IF LIVING / AGE AT TIME OF DEATH AND CAUSE)
FATHER: \_\_\_\_\_ / \_\_\_\_\_
MOTHER: \_\_\_\_\_ / \_\_\_\_\_
SIBLING: \_\_\_\_\_ / \_\_\_\_\_
SIBLING: \_\_\_\_\_ / \_\_\_\_\_
2. 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 \_\_\_\_\_
[ ] ELECTROCARDIOGRAM (EKG), IF TAKEN WITHIN PAST YR.:
RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_
[ ] STRESS EKG OR THALLIUM, IF TAKEN WITHIN PAST YEAR:
RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] SIGMOIDOSCOPY, IF TAKEN WITHIN PAST YEAR:
RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_
[ ] PROSTATE EXAM, IF TAKEN WITHIN THE PAST YEAR:
RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_
[ ] MAMMOGRAM, IF TAKEN WITHIN THE PAST YEAR:
RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_
2. HEIGHT \_\_\_\_\_ / WEIGHT \_\_\_\_\_
WEIGHT 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 WITHIN THE PAST YEAR?
[ ] NO [ ] YES, PLEASE DETAIL RESULTS:
[ ] NORMAL [ ] OTHER \_\_\_\_\_
4. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR KIDNEY TRANSPLANTS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. WHAT DISORDER MADE THE KIDNEY TRANSPLANT NECESSARY?

- KIDNEY FAILURE DUE TO DIABETES
- KIDNEY FAILURE DUE TO GLOMERULONEPHRITIS
- KIDNEY FAILURE DUE TO POLYCYSTIC KIDNEY DISEASE

OTHER, PLEASE SPECIFY \_\_\_\_\_

2. DATE OF THE TRANSPLANT \_\_\_\_\_

3. SOURCE OF THE TRANSPLANTED KIDNEY:

- IDENTICAL TWIN
- RELATED DONOR WITH IDENTICAL HLA PHENOTYPIC MATCH
- RELATED DONOR W/O IDENTICAL HLA PHENOTYPIC MATCH
- NON-RELATED LIVE DONOR
- NON-RELATED CADAVER KIDNEY

4. ARE THERE ANY CURRENT SYMPTOMS / COMPLICATIONS?

NO [ ] YES, PLEASE GIVE DETAILS \_\_\_\_\_

\_\_\_\_\_

5. GIVE RESULTS OF MOST RECENT KIDNEY FUNCTION TESTS:

BUN \_\_\_\_\_

SERUM CREATINE \_\_\_\_\_

URINALYSIS \_\_\_\_\_

6. PLEASE NOTE IF ANY OF THE FOLLOWING HAVE OCCURRED (CHECK ALL THAT APPLY):

- FREQUENT INFECTION
- REJECTION EPISODES
- HIGH BLOOD PRESSURE
- CARDIOVASCULAR DISEASE
- TOXICITY FROM TREATMENT
- CANCER
- DISEASE RECURRENCE

7. WHAT TREATMENT IS CURRENTLY BEING PRESCRIBED?

LIST MEDICATIONS AND DOSAGE \_\_\_\_\_

\_\_\_\_\_

8. WHEN WAS THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOWUP ON THE TRANSPLANT?

\_\_\_\_\_

9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR MULTIPLE SCLEROSIS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [  ] M [  ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. DATE MULTIPLE SCLEROSIS WAS DIAGNOSED \_\_\_\_\_

2. IS MULTIPLE SCLEROSIS ACTIVE?  
[  ] NO [  ] YES

WHAT IS THE DATE OF THE LAST ATTACK \_\_\_\_\_

3. WHAT IS THE DEGREE OF SEVERITY OF M.S.?

[  ] MILD  
TOTAL 2 TO 4, MILD EXACERBATIONS WITH NO RESIDUALS  
[  ] MODERATE  
SLOWLY PROGRESSIVE, ONE OR TWO ATTACKS PER YEAR  
WITH RECOVERY BETWEEN ATTACKS,  
SOME MODERATE RESIDUALS, SUCH AS CANE USE  
[  ] SEVERE  
PROGRESSIVE, MORE THAN 2 ATTACKS PER YEAR, WHEEL  
CHAIR CONFINEMENT, BEDRIDDEN  
[  ] RAPIDLY PROGRESSING SYMPTOMS

4. CURRENT SYMPTOMS (CHECK ALL THAT HAVE OCCURRED  
OVER THE PAST TWO YEARS):

[  ] VISUAL DIFFICULTIES  
[  ] NUMBNESS  
[  ] WEAKNESS OR FATIGUE  
[  ] IMPAIRED SWALLOWING  
[  ] FREQUENT BLADDER INFECTIONS  
[  ] BOWEL CONTROL DIFFICULTIES  
[  ] USE OF CANE  
[  ] USE OF WHEEL CHAIR  
[  ] DIFFICULTY WITH SPEECH

5. 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

6. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG  
WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE  
AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR OTHER ILLNESSES

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [  ] M [  ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST ILLNESS(ES) AND DETAILS (INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE 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, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR PARALYSIS AND SPINAL CORD INJURY

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

---

## 1. WHAT CAUSED THE PARALYSIS?

[ ] TRAUMA, GIVE DETAILS AND DATE OF OCCURRENCE  
\_\_\_\_\_  
\_\_\_\_\_  
[ ] SURGERY, DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE  
\_\_\_\_\_  
\_\_\_\_\_  
[ ] STROKE OR CEREBRAL VASCULAR ACCIDENT  
[ ] OTHER, PLEASE GIVE DETAILS \_\_\_\_\_  
\_\_\_\_\_

## 2. PLEASE NOTE CURRENT LEVEL OF FUNCTION:

[ ] INCOMPLETE PARAPLEGIA  
[ ] COMPLETE PARAPLEGIA  
[ ] INCOMPLETE QUADRIPLÉGIA  
[ ] COMPLETE QUADRIPLÉGIA  
3. IF PARALYSIS FROM INJURY OR TRAUMA, AT WHAT SPINAL CORD LEVEL (LIST SPECIFIC VERTEBRAE IF AVAILABLE, C7-8, FOR EXAMPLE):  
[ ] CERVICAL SPINE \_\_\_\_\_  
[ ] THORACIC SPINE \_\_\_\_\_  
[ ] LUMBROSACRAL SPINE \_\_\_\_\_

## 4. HAVE ANY OF THE FOLLOWING OCCURRED (CHECK ALL THAT APPLY):

[ ] PNEUMONIA  
[ ] SKIN ULCERS  
[ ] URINARY TRACT INFECTION  
[ ] KIDNEY IMPAIRMENT  
[ ] DEPRESSION

## 5. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS (CHECK ALL THAT APPLY):

[ ] NORMAL BLADDER FUNCTION, OR [ ] NEEDS ASSISTANCE  
[ ] NORMAL BOWEL FUNCTIONS, OR [ ] NEEDS ASSISTANCE  
[ ] USES CANE ONLY  
[ ] WHEEL CHAIR BOUND  
[ ] BED BOUND  
[ ] NEEDS ASSISTANCE EATING  
[ ] NEEDS ASSISTANCE TO COMMUNICATE

## 6. IS TREATMENT CURRENTLY BEING PRESCRIBED?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_  
\_\_\_\_\_

## 7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR PARKINSON'S DISEASE

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST THE DATE OF THE FIRST DIAGNOSIS \_\_\_\_\_

2. PLEASE NOTE THE CURRENT FUNCTIONAL STAGE:

- [ ] STAGE 1: UNILATERAL INVOLVEMENT
- [ ] STAGE 2: BILATERAL INVOLVEMENT, BUT NORMAL STANCE
- [ ] STAGE 3: BILATERAL INVOLVEMENT WITH MILD POSTURAL MBALANCE BUT ABLE TO LEAD AN INDEPENDENT LIFE
- [ ] STAGE 4: BILATERAL INVOLVEMENT WITH POSTURAL INSTABILITY, REQUIRES SUBSTANTIAL HELP
- [ ] STAGE 5: SEVERE DISEASE, RESTRICTED TO BED OR WHEELCHAIR

3. HAS THERE BEEN ANY EVIDENCE OF PROGRESSION?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_  
\_\_\_\_\_

4. PLEASE NOTE IF ANY OF THE FOLLOWING HAVE OCCURRED (CHECK ALL THAT APPLY):

- [ ] DEMENTIA
- [ ] MEMORY PROBLEMS
- [ ] ASPIRATION
- [ ] RECURRENT INFECTIONS
- [ ] FALLS
- [ ] RECURRENT INJURIES

5. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR PREFERRED RISK

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. PLEASE DETAIL THE CLIENT'S FAMILY HISTORY:  
(AGE IF LIVING / AGE AT TIME OF DEATH AND CAUSE)

FATHER: \_\_\_\_\_ / \_\_\_\_\_  
MOTHER: \_\_\_\_\_ / \_\_\_\_\_  
SIBLING: \_\_\_\_\_ / \_\_\_\_\_  
SIBLING: \_\_\_\_\_ / \_\_\_\_\_

2. 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 \_\_\_\_\_

[ ] ELECTROCARDIOGRAM (EKG), IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] STRESS EKG OR THALLIUM IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] SIGMOIDOSCOPY, IF TAKEN WITHIN PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] PROSTATE EXAM IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

[ ] MAMMOGRAM IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [ ] NORMAL [ ] OTHER \_\_\_\_\_

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP WITHIN THE PAST YEAR?

[ ] NO [ ] YES, PLEASE DETAIL RESULTS:

[ ] NORMAL [ ] OTHER \_\_\_\_\_

4. DOES THE CLIENT PARTICIPATE IN AVIATION / AVOCATION ACTIVITIES?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

5. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR PULMONARY DISEASE

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_  
AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_  
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 \_\_\_\_\_  
LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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## 1. TYPE OF LUNG DISEASE

- CHRONIC BRONCHITIS
- EMPHYSEMA
- RESTRICTIVE LUNG DISEASE
- ASTHMA

2. PLEASE LIST DATE WHEN FIRST DIAGNOSED \_\_\_\_\_

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

[ ] NO [ ] YES, PLEASE GIVE DATE \_\_\_\_\_

4. HAS THE CLIENT EVER SMOKED?

[ ] YES, CURRENTLY SMOKES \_\_\_\_\_ (AMOUNT/DAY)

[ ] YES, SMOKED IN THE PAST BUT QUIT \_\_\_\_\_ (DATE)

[ ] NO, NEVER SMOKED

5. IS YOUR CLIENT ON ANY MEDICATION OR AN INHALER FOR THE DISEASE?

[ ] NO [ ] YES, DETAILS \_\_\_\_\_

6. HAS THE CLIENT HAD A RECENT PUMONARY FUNCTION (BREATHING TEST)?

[ ] NO [ ] YES, PLEASE GIVE RESULTS \_\_\_\_\_

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON AN ACG OR X-RAY?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR RHEUMATOID ARTHRITIS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST THE DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. IS THE CLIENT ON ANY MEDICATIONS FOR THE DISEASE?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

3. HAS YOUR CLIENT EXPERIENCED ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

- [ ] WEIGHT LOSS
- [ ] FEVER
- [ ] LOW BLOOD COUNTS
- [ ] HEART DISEASE
- [ ] LUNG DISEASE
- [ ] LIVER ENZYME ABNORMALITY
- [ ] KIDNEY DISEASE

4. PLEASE LIST FUNCTIONAL ABILITY:

- [ ] FULLY ACTIVE
- [ ] SEDENTARY
- [ ] USES WALKER, CANE, ETC.
- [ ] USES WHEELCHAIR

5. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR SARCOIDOSIS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. WAS A BIOPSY DONE? [ ] YES [ ] NO

3. PLEASE NOTE STAGE DIAGNOSED \_\_\_\_\_

4. HOW WAS THE SARCOID TREATED?

[ ] PREDNISONE  
[ ] NO TREATMENT

DATE TREATMENT WAS COMPLETED \_\_\_\_\_

5. IS THE CLIENT ON ANY MEDICATIONS FOR THIS IMPAIRMENT?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

---

6. PLEASE NOTE WHICH ORGANS WERE INVOLVED (CHECK ALL THAT APPLY):

[ ] LUNG  
[ ] HEART  
[ ] LIVER  
[ ] SPLEEN  
[ ] EYES  
[ ] KIDNEY  
[ ] CENTRAL NERVOUS SYSTEM  
[ ] SKIN  
[ ] LYMPH NODES

7. PLEASE GIVE RESULTS OF THE MOST RECENT PULMONARY FUNCTION TEST:

FVC \_\_\_\_\_ FEV1 \_\_\_\_\_

8. HAS THERE BEEN ANY EVIDENCE OF RECURRENCE/ PROGRESSION?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

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9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

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# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR SLEEP APNEA

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME \_\_\_\_\_ / [ ] M [ ] F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE GIVE DATE OF DIAGNOSIS \_\_\_\_\_

2. PLEASE NOTE TYPE DIAGNOSED:

- OBSTRUCTIVE
- CENTRAL
- MIXED

3. HAS A SLEEP STUDY, OR STUDIES, BEEN COMPLETED?

[ ] YES [ ] NO IF YES, PLEASE NOTE DATE(S) OF STUDY(IES):

FIRST STUDY \_\_\_\_\_ LAST STUDY \_\_\_\_\_

AND NOTE THE FOLLOWING:

OXYGEN SATURATION LEVEL \_\_\_\_\_

APNEA INDEX RESULTS \_\_\_\_\_

4. WHAT TREATMENT HAS BEEN PRESCRIBED (PLEASE CHECK ALL THAT APPLY):

- OBSERVATION ALONE
- WEIGHT LOSS ALONE
- CPAP (CONTINUOUS POSITIVE AIRWAY PRESSURE) MASK

IF CHECKED, DATE LAST USED \_\_\_\_\_

[ ] SURGERY  
(TRACHEOTOMY OR UVULOPALATOPHARYNGOPLASTY)

[ ] MEDICATION, PLEASE DETAIL TYPE AND DOSAGE:

5. ARE THERE ANY CURRENT SYMPTOMS?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

6. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING ILLNESSES (CHECK ALL THAT APPLY, AND GIVE DETAILS):

[ ] ARRHYTHMIA, TYPE \_\_\_\_\_

[ ] OTHER HEART RELATED CONDITION, TYPE \_\_\_\_\_

[ ] ASTHMA, COPD OR EMPHYSEMA, TYPE \_\_\_\_\_

[ ] DEPRESSION

[ ] OVERWEIGHT, PLEASE CONFIRM HEIGHT AND WEIGHT

HEIGHT \_\_\_\_\_ / WEIGHT \_\_\_\_\_

7. HAS THE CLIENT SMOKED CIGARETTES IN THE PAST 12 MONTHS?

[ ] NO [ ] YES, PLEASE DETAIL AMOUNT PER DAY AND DATE STOPPED, IF NO LONGER SMOKING:

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR SYSTEMIC LUPUS ERYTHEMATOSUS

## (SLE)

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 \_\_\_\_\_

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST THE DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. PLEASE NOTE THE TYPE OF LUPUS DIAGNOSED:

[ ] SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

[ ] DISCOID LUPUS

[ ] DRUG INDUCED LUPUS

3. IS THE CLIENT ON ANY MEDICATIONS FOR THIS IMPAIRMENT?

[ ] NO [ ] YES, PLEASE DETAIL TYPE AND DOSAGE \_\_\_\_\_

\_\_\_\_\_

4. IS THE LUPUS IN REMISSION?

[ ] YES [ ] NO, PLEASE LIST DATE OF LAST EXACERBATION

\_\_\_\_\_

5. HAS THE CLIENT HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

[ ] LOW BLOOD COUNTS

[ ] LUNG INVOLVEMENT (PLEURITIS)

[ ] PROTEINURIA

[ ] HIGH BLOOD PRESSURE

[ ] NEUROLOGIC DISORDER

[ ] HEART INVOLVEMENT (PERICARDITIS)

[ ] RENAL INSUFFICIENCY OR FAILURE

6. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

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