

Brokerage Concepts, Inc.
Quick Quote Form

Please fax completed form to:

(610)878-9614

to the attention of:

Life Brokerage Manager

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.

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 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:

