

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 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.

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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. 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:

\_\_\_\_\_

\_\_\_\_\_

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