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 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:

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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:

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