

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 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.

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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 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:

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