

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 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:

\_\_\_\_\_

\_\_\_\_\_