

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 OTHER ILLNESSES

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. PLEASE LIST ILLNESS(ES) AND DETAILS (INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE OR AMOUNT OF TREATMENT, ON EACH):

TYPE/SEVERITY _____
DATE OF DIAGNOSIS: MONTH _____ YEAR _____
TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
[] SURGERY [] MEDICATION [] OTHER

TYPE/SEVERITY _____
DATE OF DIAGNOSIS: MONTH _____ YEAR _____
TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
[] SURGERY [] MEDICATION [] OTHER

TYPE/SEVERITY _____
DATE OF DIAGNOSIS: MONTH _____ YEAR _____
TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
[] SURGERY [] MEDICATION [] OTHER

2. 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

3. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

