

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 PARALYSIS AND SPINAL CORD INJURY**

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. WHAT CAUSED THE PARALYSIS?

[ ] TRAUMA, GIVE DETAILS AND DATE OF OCCURRENCE
\_\_\_\_\_
[ ] SURGERY, DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE
\_\_\_\_\_
[ ] STROKE OR CEREBRAL VASCULAR ACCIDENT
[ ] OTHER, PLEASE GIVE DETAILS \_\_\_\_\_

2. PLEASE NOTE CURRENT LEVEL OF FUNCTION:

[ ] INCOMPLETE PARAPLEGIA
[ ] COMPLETE PARAPLEGIA
[ ] INCOMPLETE QUADRIPLÉGIA
[ ] COMPLETE QUADRIPLÉGIA
3. IF PARALYSIS FROM INJURY OR TRAUMA, AT WHAT SPINAL CORD LEVEL (LIST SPECIFIC VERTEBRAE IF AVAILABLE, C7-8, FOR EXAMPLE):
[ ] CERVICAL SPINE \_\_\_\_\_
[ ] THORACIC SPINE \_\_\_\_\_
[ ] LUMBROSACRAL SPINE \_\_\_\_\_

4. HAVE ANY OF THE FOLLOWING OCCURRED (CHECK ALL THAT APPLY):

[ ] PNEUMONIA
[ ] SKIN ULCERS
[ ] URINARY TRACT INFECTION
[ ] KIDNEY IMPAIRMENT
[ ] DEPRESSION

5. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS (CHECK ALL THAT APPLY):

[ ] NORMAL BLADDER FUNCTION, OR [ ] NEEDS ASSISTANCE
[ ] NORMAL BOWEL FUNCTIONS, OR [ ] NEEDS ASSISTANCE
[ ] USES CANE ONLY
[ ] WHEEL CHAIR BOUND
[ ] BED BOUND
[ ] NEEDS ASSISTANCE EATING
[ ] NEEDS ASSISTANCE TO COMMUNICATE

6. IS TREATMENT CURRENTLY BEING PRESCRIBED?

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

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

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