

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 PREFERRED RISK

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 DETAIL THE CLIENT'S FAMILY HISTORY:
(AGE IF LIVING / AGE AT TIME OF DEATH AND CAUSE)

FATHER: _____ / _____
MOTHER: _____ / _____
SIBLING: _____ / _____
SIBLING: _____ / _____

2. DETAIL THE CLIENT'S MEDICAL HISTORY (CHECK ALL THAT APPLY):

[] CANCER HISTORY
[] HEART HISTORY/CONDITION
[] DIABETES HISTORY
[] ALCOHOL OR DRUG ABUSE HISTORY
[] HIGH BLOOD PRESSURE, PLEASE DETAIL:

CURRENT READING _____ / HIGHEST READING _____

TYPE OF TREATMENT _____

[] ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING _____ / HDL READING OR RATIO _____

HIGHEST CHOLESTEROL READING _____

TYPE OF TREATMENT _____

[] ELECTROCARDIOGRAM (EKG), IF TAKEN WITHIN PAST YEAR:

RESULTS: [] NORMAL [] OTHER _____

[] STRESS EKG OR THALLIUM IF TAKEN WITHIN PAST YEAR:

RESULTS: [] NORMAL [] OTHER _____

[] SIGMOIDOSCOPY, IF TAKEN WITHIN PAST YEAR:

RESULTS: [] NORMAL [] OTHER _____

[] PROSTATE EXAM IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [] NORMAL [] OTHER _____

[] MAMMOGRAM IF TAKEN WITHIN THE PAST YEAR:

RESULTS: [] NORMAL [] OTHER _____

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP WITHIN THE PAST YEAR?

[] NO [] YES, PLEASE DETAIL RESULTS:

[] NORMAL [] OTHER _____

4. DOES THE CLIENT PARTICIPATE IN AVIATION / AVOCATION ACTIVITIES?

[] NO [] YES, PLEASE DETAIL _____

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

