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 PULMONARY DISEASE

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 _____________________

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1. TYPE OF LUNG DISEASE

[ ] CHRONIC BRONCHITIS
[ ] EMPHYSEMA
[ ] RESTRICTIVE LUNG DISEASE
[ ] ASTHMA

2. PLEASE LIST DATE WHEN FIRST DIAGNOSED _____________

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

[ ] NO [ ] YES, PLEASE GIVE DATE _________________________

4. HAS THE CLIENT EVER SMOKED?

[ ] YES, CURRENTLY SMOKES _______________ (AMOUNT/DAY)

[ ] YES, SMOKED IN THE PAST BUT QUIT _____________ (DATE)

[ ] NO, NEVER SMOKED

5. IS YOUR CLIENT ON ANY MEDICATION OR AN INHALER FOR THE DISEASE?

[ ] NO [ ] YES, DETAILS __________________________________

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6. HAS THE CLIENT HAD A RECENT PUMONARY FUNCTION (BREATHING TEST)?

[ ] NO [ ] YES, PLEASE GIVE RESULTS ____________________

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON AN ACG OR X-RAY?

[ ] NO [ ] YES, PLEASE DETAIL ____________________________

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

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