# INFORMAL INQUIRY

*Not an application for life insurance*

*Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.*

# PRODUCER INFORMATION

Producer: Date:

Face Amount: Product:

# PROPOSED INSURED INFORMATION

Applicant Name: ☐ Male ☐ Female DOB: City: State: Zip Code: Occupation: Income: Assets: Liabilities: Net Worth:

# INSURANCE CURRENTLY IN FORCE

|  |  |  |  |
| --- | --- | --- | --- |
| Company | Year Issued | Face Amount | Being Replaced? |
|  |  |  | * Yes
 | * No
 |
|  |  |  | * Yes
 | * No
 |
|  |  |  | * Yes
 | * No
 |
|  |  |  | * Yes
 | * No
 |

**ACTIVITY AND MEDICAL INFORMATION**

Do you participate in any hazardous activities? ☐ Flying ☐ Scuba ☐ Climbing ☐ Other Details:

Do you have any plans for foreign travel? ☐ Yes ☐ No

Details:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever used any kind of tobacco product? |  | * Yes
 | * No
 |  |
| Forms Used: ☐ Cigarette | * Pipe
 | * Gum
 | * Patch
 | * Cigar
 | * Other
 |

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other

Date last used:

Do you have any knowledge that an application or informal inquiry has been seen by any carrier in the last year?

* Yes

|  |  |  |
| --- | --- | --- |
| Company | Offer | Placed? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* No

Height: Weight:

# ACTIVITY AND MEDICAL INFORMATION, CONTINUED

Do you have a history of:

High Blood Pressure ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease ☐ Yes ☐ No

* + Heart Attack ☐ Bypass Surgery Date of event:
	+ Stent(s) Date of Last EKG/Stress Test:

Diabetes ☐ Yes ☐ No

At what age were you diagnosed?

List all diabetes medications currently prescribed:

Medication: Dosage: Medication: Dosage: Medication: Dosage: Most recent A1c level: Current glucose reading:

Respiratory Disease ☐ Yes ☐ No

Have you been hospitalized for this condition: ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you currently using a CPAP? ☐ Yes ☐ No Date of last pulmonary function test:

Cancer ☐ Yes ☐ No

Type of cancer: Was there a biopsy? ☐ Yes ☐ No Cancer stage if known: Date of surgery, if any? Date of completion of radiation treatment: Date of completion of chemotherapy:

Please list any medical conditions not indicated above:

Please list all medications being taken:

# FAMILY MEDICAL HISTORY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Member | AgeIf deceased, age @ death and cause | History of Heart Disease? | History of Cancer? | Type |
| Mother |  | * Yes
 | * No
 | * Yes
 | * No
 |
| Father |  | * Yes
 | * No
 | * Yes
 | * No
 |
| Sibling 1 |  | * Yes
 | * No
 | * Yes
 | * No
 |
| Sibling 2 |  | * Yes
 | * No
 | * Yes
 | * No
 |

**SENIOR SUPPLEMENT**

|  |  |  |
| --- | --- | --- |
| Have you been diagnosed with Alzheimer's or dementia? | * Yes
 | * No
 |
| Have you ever been treated for memory problems? | * Yes
 | * No
 |
| Do you require assistance for walking? | * Yes
 | * No
 |
| Do you have a history of falls? | * Yes
 | * No
 |
| Do you exercise on a daily basis? | * Yes
 | * No
 |
| Do you require assistance with daily chores? | * Yes
 | * No
 |
| Do you drink alcohol? | * Yes
 | * No
 |
| Have you ever been diagnosed with depression? | * Yes
 | * No
 |
| Have you ever been diagnosed with anemia? | * Yes
 | * No
 |

Please provide details of any "Yes" answers above:

Please list all medications being taken:

# ADDITIONAL NOTES