BROKERAGE SOLUTIONS

2001 Market St, Suite 2500
Philadelphia, PA. 19103
(215) 242-7505
inquiries@brokeragesolutions.com
brokeragesolutions.com

INFORMAL INQUIRY

Not an application for life insurance

PRODUCER INFORMATION

Producer: _____ Date: _____

Product: _____ Face Amount: _____

PROPOSED INSURED INFORMATION

Applicant Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Social Security Number: _____ Drivers License Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Annual Income: _____

Total Assets: $_____ Total Liabilities: $_____ Net Worth: $_____

Premium Tolerance/Offer Needed to Place: $_____

Can you provide third-party financials signed by a currently licensed CPA? ☐ Yes ☐ No

INSURANCE CURRENTLY IN FORCE

COMPANY	YEAR ISSUED	FACE AMOUNT	BEING REPLACED?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

To your knowledge, have any life insurance applications or informal inquiries been submitted to or reviewed by any carriers to potentially insure this applicant in the past 12 months? ☐ Yes ☐ No

If yes, please provide details:

COMPANY	OFFER RECEIVED	POLICY PLACED?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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ACTIVITY AND MEDICAL INFORMATION

Height: _____ feet _____ inches **Weight:** _____ lbs

Do you participation in any hazardous activities? ☐ Flying ☐ SCUBA ☐ Climbing ☐ Other _____

Please provide details: _____

_____

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

If yes, please provide details: _____

_____

Have you ever used any form(s) of tobacco or nicotine product? ☐ Yes ☐ No

If yes, what form(s)? ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Gum ☐ Patch ☐ Other _____

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Date last used: _____

Do you have a history of any of the following?

High Blood Pressure ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease ☐ Yes ☐ No

Have you experienced any of the following conditions: ☐ Heart Attack ☐ Bypass Surgery ☐ Stent(s)

Date of Event: _____ 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: _____

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Do you have a history of any of the following? *(continued)*

Respiratory Disease ☐ Yes ☐ No

Have you ever 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: _____

Did you have a biopsy? ☐ Yes ☐ No

Cancer stage, if known: _____ Date of surgery, if performed: _____

Date radiation treatment completed: _____ Date chemotherapy completed: _____

Please list any medical conditions not indicated above: _____

_____

_____

FAMILY MEDICAL HISTORY

FAMILY MEMBER	AGE If deceased, age at death & cause	HISTORY OF HEART DISEASE?	HISTORY OF CANCER?
Mother		☐ Yes ☐ No	☐ Yes ☐ No Type: _____
Father		☐ Yes ☐ No	☐ Yes ☐ No Type: _____
Sibling One		☐ Yes ☐ No	☐ Yes ☐ No Type: _____
Sibling Two		☐ Yes ☐ No	☐ Yes ☐ No Type: _____

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

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SENIOR SUPPLEMENT *(Continued)*

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 list all medications currently being taken: _____

_____

_____

Please provide details for any condition you answered "yes" to above: _____

_____

_____

PHYSICIAN INFORMATION

Primary Care Physician

Physician Name: _____ Office Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Last Visit: _____ Reason: _____

Specialty Care Physician One

Physician Name: _____ Office Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Last Visit: _____ Reason: _____

Specialty Care Physician Two

Physician Name: _____ Office Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Last Visit: _____ Reason: _____

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ADDITIONAL NOTES