

Preliminary Inquiry

Not an application for life insurance. This Preliminary Inquiry is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.



Date: _____ Advisor Name: _____ Advisor Phone: (_____) _____

Insured Name: _____ Date of Birth: _____

Insured Email: _____

Earned Income: \$ _____ Unearned Income: \$ _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Male Female SS#: _____ DL#: _____

Any weight change (10 pounds or more) in the last year? Yes No If "YES," how much? _____

Reason for change: _____

Does insured currently use tobacco in any form (cigarettes, cigars, chewing tobacco, etc.)? Yes Past Never

If "YES," please specify the form of tobacco and the quantity used: _____

If "PAST" what form and when did insured quit? _____

Please list all medication(s) including dosage:

MEDICATION NAME	DOSAGE	FREQUENCY	PURPOSE

Family history of insured's (parents and siblings): Indicate diagnosis of heart disease or cancer, age at diagnosis, and current age or age at death. If deceased, indicate cause of death: _____

Current blood pressure: _____ Current cholesterol level: _____ Ratio: _____ HDL: _____ LDL: _____

For the following, please complete the appropriate corresponding Preliminary Inquiry-Detail Form and submit along with this form.

Has the insured been treated for any of the following? (check all that apply and provide initial treatment date)

- Alcohol/Drugs _____ Diabetes _____ Lung Disorders _____
- Cancer _____ Hypertension _____ Sleep Apnea _____
- Cardiac _____ Depression _____ Other: _____

Please list all doctors the insured has seen in the last five years:

NAME AND SPECIALTY	CITY, STATE	PHONE NUMBER	WHEN? / WHY?

Do you have access to your medical records through a patient portal? Yes No

If yes, would you please login to that portal and forward the records to us.

Drug and Alcohol Usage

Check here if this section is not applicable

Does insured currently drink alcohol? Yes No

Date of last consumption: _____

Note amount per week below:

Beer: _____

Wine: _____

Liquor: _____

Did insured ever drink substantially more than at present? Yes No

If yes, when? _____

Note amount per week below:

Beer: _____

Wine: _____

Liquor: _____

Has insured ever consulted a doctor or received treatment because of alcohol use? Yes No

Has insured ever been arrested for driving under the influence of alcohol or drugs? Yes No

If yes, provide date(s): _____

Has insured ever sought medical treatment because of drug use or has drug use ever been a problem? Yes No

If yes, provide details: _____

Type of drug(s) used: _____ Date of last use: _____

Aviation, Avocation and Foreign Travel: Has the insured been involved in any of the following activities: foreign travel, aviation, sky diving, scuba diving, motor racing or any other hobby with unusual risk? (if "YES," please provide detail and an additional form will be provided) _____

Driving Record: How many moving violations has the insured received in the past three years? _____

Is insured a U.S. citizen? Yes No If "NO," please note immigration status: _____

Face amount: _____ Plan desired: _____ Amount in-force: _____

Has this case recently been submitted to another carrier or broker? Yes No

If "YES," what is the status or what was the outcome? _____

CURRENT OFFERS	CARRIER	PREMIUM	CLASS	DECLINE, WHY?