BackNine Insurance

QUICK QUOTE FOR OTHER ILLNESSES

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative 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 _____

AMT. 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 __________

1. PLEASE LIST ILLNESS(ES) AND DETAILS (INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE OR AMOUNT OF TREATMENT, ON EACH):

TYPE/SEVERITY ______________________

DATE OF DIAGNOSIS: MONTH __________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

TYPE/SEVERITY ______________________

DATE OF DIAGNOSIS: MONTH __________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

TYPE/SEVERITY ______________________

DATE OF DIAGNOSIS: MONTH __________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

2. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

❑ 0 TO 6 MONTHS AGO
❑ 6 TO 12 MONTHS AGO
❑ 12 TO 24 MONTHS AGO
❑ OVER 2 YEARS AGO

3. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

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