

# Preliminary Inquiry for Insurance Quote



Not an application for 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: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Income: \_\_\_\_\_ Current Net Worth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Male  Female

Any weight change (ten pounds or more) in the last year? Yes  No  If "Yes," how much? \_\_\_\_\_

Reason for change: \_\_\_\_\_

Do you currently use tobacco in any form (cigarettes, cigars, chewing tobacco, etc.)? Yes  No

If "Yes", please specify the form of tobacco and the quantity used. \_\_\_\_\_

If you no longer use tobacco in any form, when did you quit? \_\_\_\_\_

List medication(s) including the dosage: \_\_\_\_\_

Family History (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. \_\_\_\_\_

Have you 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 seen in the last five years:

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

**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 (3) years? \_\_\_\_\_

Have you ever been arrested for driving under the influence of alcohol or drugs? Yes  No

If "Yes", how many times? \_\_\_\_\_

Are you a U.S. citizen? Yes  No  If No, please note immigration status: \_\_\_\_\_

Amount of current coverage: \_\_\_\_\_ New coverage requested: \_\_\_\_\_

Length of Coverage Needed (in years): 10  15  20  25  30  Lifetime

Frequency of Premium Payments Requested: Annual  Semi-Annual  Quarterly  Monthly (EFT)

Have you recently submitted this case to another carrier or broker? Yes  No

If "Yes", what is the status or what was the outcome? \_\_\_\_\_