

BUILD QUESTIONNAIRE

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, AGE AND CAUSE, OF EACH _____

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. DETAIL THE CLIENT'S MEDICAL HISTORY (CHECK ALL THAT APPLY):

- CANCER HISTORY
- HEART HISTORY / CONDITION
- DIABETES HISTORY
- ALCOHOL OR DRUG ABUSE HISTORY
- HIGH BLOOD PRESSURE, PLEASE DETAIL:

CURRENT READING _____ / HIGHEST READING _____

TYPE OF TREATMENT _____

- ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING _____ / HDL READING OR RATIO _____

HIGHEST CHOLESTEROL READING _____

TYPE OF TREATMENT _____

2. HT _____ WT _____ / WT LOSS IN LAST YEAR _____

LAST MEASURED BODY FAT % _____ / DATE _____

MEN ONLY: CHEST SIZE _____ IN. / WAIST SIZE _____ IN.

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP W/IN THE PAST YEAR:

NO YES, PLEASE DETAIL: NORMAL OTHER _____

4. 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):

