

# Preliminary Insurance Fact Finder



Please complete as much information as possible to facilitate the underwriting and/or pre-screening process.



## Personal Health Information

**Proposed Insured's**

**Date of Birth:** \_\_\_\_\_

**Legal Name:** \_\_\_\_\_

**Plan of Insurance requested:**

**Individual:** Term UL VUL WL  
LTC LTC Hybrid

**Survivorship:** SUL SVUL SWL

**Rate Class Desired**

**Face Amount Desired:** \$ \_\_\_\_\_

Best Rate

Preferred

Standard

Rated: \_\_\_\_\_

**Are you applying to any other carrier? Y / No**

**Have you in the past ever been declined, rated, or postponed? Y / N**

**If yes, when, what carrier, and what reason? \_\_\_\_\_**

### *Medical and Lifestyle Assessment*

**Present Nicotine Use:**

None Cigarettes – frequency of use per day: \_\_\_\_\_  
Cigars Pipe Dip Chew Nicotine Gum Other: \_\_\_\_\_

Quantity per month: \_\_\_\_\_

Former Tobacco User: List each type of tobacco, quantity and frequency used, and date of last use: \_\_\_\_\_

**Build:**

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds.

Any weight gain or loss in the past year (greater than 10#)? Details: \_\_\_\_\_

**Family History** (*Family history is a consideration for each rate class*):

To your knowledge, is there any family history (parent or siblings) of disease due to cardiovascular, cerebrovascular disease, diabetes or cancer?  No  Yes

If Yes, provide full details with the specific impairment, age at onset, and age at death if deceased:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

**Blood Pressure and Cholesterol:**

Latest BP reading: \_\_\_\_\_/\_\_\_\_\_. Latest Total Cholesterol: \_\_\_\_\_ mg. Latest cholesterol/HDL ratio: \_\_\_\_\_

Are you currently taking any medication for blood pressure?  No  Yes, Name of medication: \_\_\_\_\_

Are you currently taking any medication to lower cholesterol?  No  Yes, Name of medication: \_\_\_\_\_

**Aviation/Avocation:**

In the past 5 years have you or do you intend to participate in any hazardous activities?

- None  Flying  Racing  Sky Diving  Scuba Diving  Mountain Climbing  Other: \_\_\_\_\_

Details: \_\_\_\_\_

**Citizenship/Residency/Travel**

US Citizen:  Yes  No

If no, provide type and expiration of visa, green card status and length of time in the USA: \_\_\_\_\_

Any future plans to live or travel outside of the USA?  No  Yes (provide purpose, cities, countries, frequency and duration): \_\_\_\_\_

**Driving History:**

Have you had any of the following motor vehicle related incidents in the past 10 years?

- Moving Violation  Reckless Driving  DWI  DUI  License suspension  License revoked

Provide Dates and details: \_\_\_\_\_

**Medical History:**

Have you ever had, been told you had, or been treated for any of the conditions listed below? If yes, check all that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol or Drug abuse   | <input type="checkbox"/> Cerebrovascular disease          | <input type="checkbox"/> Kidney disease              |
| <input type="checkbox"/> Alzheimer's/dementia/   | <input type="checkbox"/> Crohn's disease                  | <input type="checkbox"/> Lupus                       |
| <input type="checkbox"/> Cognitive impairment    | <input type="checkbox"/> Depression/anxiety               | <input type="checkbox"/> Multiple sclerosis          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Rheumatoid arthritis        |
| <input type="checkbox"/> Cirrhosis               | <input type="checkbox"/> Heart murmur/valve disease       | <input type="checkbox"/> Sleep apnea                 |
| <input type="checkbox"/> COPD                    | <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Irregular heartbeat/palpitations | <input type="checkbox"/> Other _____                 |

List all medications taken, dosage and/or frequency, the reason being taken, and the name of prescribing physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all diagnosis, dates consulted and treatment details as well as names, addresses/phone numbers of all physicians consulted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other notes, comments or concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_