



Quick Quoter Clinical Underwriting®

General Purpose

Date: ___/___/___

Agent Name	Fax	
Address	Phone	
City	State	Zip

Client's Name: _____ Date of Birth: ___/___/___

Sex: Male Female Height: _____ Weight: _____ lbs.

Smoker: No Yes (If yes, also complete Tobacco Questionnaire)

Insurance Amount: _____ Insurance Type: Term UL Survivor UL

Additional Insured's Name (only if applying for Survivor UL): _____

OTHER COMPANY ACTIONS: Company: _____ Date applied: ___/___/___

Declined Postponed Rated Table: _____

1. What is client's illness?: _____

Please provide details: _____

2. When was diagnosis made? ___/___/___

3. What type of treatment has been received? Surgery _____ Date ___/___/___

Medication (list) _____ Other types of treatments _____

4. When was last visit to a physician about this disorder?

0-6 months 6-12 months 12-24 months More than 24 months ago

5. Date and result of last cholesterol reading ___/___/___ Reading: _____

6. Date and result of last blood pressure reading ___/___/___ Reading: _____

7. How many times per week does client exercise?

None 1 2 3 4 5 6 7 More than 7

Type of exercise: _____

8. Are there any other illnesses/impairments? _____

9. What medication is currently being taken? _____

10. Has either parent, or any sibling, died before age 65, other than by accident? No Yes

List relationship(s): _____ Cause(s): _____

ADDITIONAL INFORMATION: _____
