LIFE INSURANCE QUOTE SHEET

Name:_____

DOB:_____ Male or Female

Phone Number:_____

Phone Number:_____

Loan Amount:_____Term:_____

Tobacco in the last 5 years: Y or N If yes, type:_____

DWI in last 5 years: Y or N if yes, year:_____

Height:_____Weight:_____

Occupation:_____

Gross Income:_____

Net Income:_____

Email Address:_____

Mailing Address:_____

Medical Information:

High Blood Pressure Controlled?

Yes, Medication:_____

Last BP Reading if known:_____

Diabetes:

Yes, Insulin or Oral Med:_____

Type 1? Type 2? AIC Number:_____Glucose:_____

Heart Attack: Y or N Year:_____

Stroke: Y or N Year:_____

Cancer: Y or N Type:_____

High Cholesterol:_____

Sleep Apnea , if yes: Uses CPAP regularly?_____

Gastric Bypass or Sleeve:_____ Month/Year:_____

Anxiety or Depression Suicidal Thoughts: Y or N

Any weight gain or loss more than 10 pounds within the past 12 months: Y or N

Medications:_____

_____

_____

Appointment Date, Time, & location:_____

_____

Best time to call back/follow up:

_____

_____

Kids/Family/Friends that need Auto/Home/Life/DI insurance? Ask!

Date of Call:

Name:_____

DOB:_____ Male or Female

Phone Number:_____

Phone Number:_____

Loan Amount:_____Term:_____

Tobacco in the last 5 years: Y or N If yes, type:_____

DWI in last 5 years: Y or N if yes, year:_____

Height:_____Weight:_____

Occupation:_____

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Email Address:_____

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Medical Information:

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Gastric Bypass or Sleeve:_____ Month/Year:_____

Anxiety or Depression Suicidal Thoughts: Y or N

Any weight gain or loss more than 10 pounds within the past 12 months: Y or N

Medications:_____

_____

_____

Company Quoted With:_____

Monthly Premium Quoted:_____

Agent Completing Form:_____

Supplemental Group Work Place Products: Colonial or Aflac