LFS INSURANCE SERVICES

# Life Insurance Quote Request

Please return form to TBunn@LFSUS.com or fax to 360-694-4007

*Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.*

## Producer Information

Name: _____ Date Needed: _____

Email (for response): _____ Phone Number: _____

## Client Information

Name: _____ State: _____ DOB: _____ Gender: ☐ M ☐ F

Height: ___'___" Weight: ____ lbs Weight loss in last 12 mos? ☐ Y ☐ N Amount _____

☐ Preferred Plus ☐ Preferred ☐ Standard Plus ☐ Standard

*Insurance Currently Inforce*

| Company | Year Issued | Face Amount | Being Replaced? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

## Policy Design

Face Amount: $ _____ Premium amount: $ _____

Product: ☐ Term ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ ROP

☐ Universal Life Goal: ☐ Guaranteed DB ☐ Cash Accumulation ☐ Both

☐ Whole Life ☐ Participating ☐ Non-Participating

Rider(s): ☐ LTC ☐ Child amount _____ ☐ Waiver of Premium ☐ Other: _____

## Medical Information

Have you ever used any kind of tobacco or marijuana products? ☐ Yes ☐ No

☐ Marijuana ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew ☐ Gum/Patch ☐ Vape

Frequency: Amount _____ ☐ Daily ☐ Weekly ☐ Monthly Date Last Used: _____

Do you have a history of the following: (check all that apply) ☐ None

☐ High Blood Pressure

☐ Heart Condition/ Coronary Artery Disease Date of event: _____

☐ Heart Attack ☐ Bypass Surgery ☐ Stent(s) Date of last EKG _____

☐ Diabetes ☐ Type 1 ☐ Type 2 Date of onset _____

A1C (required): _____ Current Glucose _____

Medication(s): _____ Dosage(s) _____

☐ Respiratory Disease

Have you need hospitalized for this condition? ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Date of last pulmonary function test _____

☐ Cancer Type: _____ Stage: _____

Type of treatment (if any) _____ Date treatment completed _____

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Please list any other medication(s) or medical condition(s):

_____

_____

_____

_____

## Activity Information

Do you participate in any hazardous activities? ☐ Yes ☐ No

☐ Flying ☐ Scuba ☐ Climbing ☐ Other

Details: _____

Do you have any plans for foreign travel? ☐ Yes ☐ No

Details: _____

## Family Medical History

| Family Member | Age<br>if deceased, age @ death and cause | History of Heart Disease? | | History of Cancer? | |
|---|---|---|---|---|---|
| Mother | | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Father | | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Sibling 1 | | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Sibling 2 | | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

## Additional Notes

_____

_____

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