LIFE QUOTE SHEET

Email Quote Forms To: Joseph@ssnainsurance.com

Agent Name ______________________ **Phone** ______________________ **Date** ____________

Proposed Insured Name ______________________ ☐ **M** ☐ **F** **Date of Birth** ____________

Face Amount ______________________ Desired Monthly Budget **Whole Life** ☐ **Survivorship**

Height/Weight ______________________ **Weight Loss/Gain in last year** ______________________

Do you currently smoke cigarettes? ☐ Yes ☐ No

If no, did you ever smoke? ☐ Never ☐ Quit (Date) ______________________

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, nicotine gum, etc) ☐ Yes ☐ No

If yes, please provide details: ______________________

When did you last use any form of tobacco? ________ (Month) ________ (Year) Type used last? ____________

Check all that applies and answer the corresponding questions.

☐ Heart Conditions — Please check all that apply

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Cardiomyopathy
- ☐ Valve Disease
- ☐ Valve Replacement

Which condition (s) and date (s) of diagnosis

____

☐ Hypertension / High Blood Pressure

Current Blood Pressure Reading ______________________ Average Blood Pressure Reading ______________________

☐ Stroke / TIA / TIA symptoms

Date of symptom and diagnosis ______________________ Recurrence of symptoms ____________

If you have any residuals, please describe:

____

☐ Diabetes ☐ Type I (Juvenile) ☐ Type II

Date of Diagnosis ____________ Current Glucose and/or Hemoglobin A1C Reading ____________

Do you use insulin? ____________ Units per day ______________________

In **combination with Diabetes**, do you have any of the following:

- ☐ Tingling
- ☐ Numbness
- ☐ Neuropathy
- ☐ Skin Ulcers
- ☐ Coronary Artery Disease
- ☐ Cellulitis
- ☐ Visual Changes
- ☐ Retinopathy
- ☐ Kidney Or Liver Problems
- ☐ Organ Damage
- ☐ Heart Disease
- ☐ TIA/Stroke
- ☐ Peripheral Vascular Disease

☐ Cancer

Type ____________ Stage or Grade ____________ Date of diagnosis ____________

Date of Last Treatment ____________ Type of treatment? ____________ Any treatment at this time? ____________

For Agent Use Only.

Any other health conditions? Provide details:

Date of your last physician office visit? ______________ Reason for visit ______________

Do you have any surgery that is pending or has been recommended? ______________

Please Explain ______________

Current Medications (Daily usage of prescription narcotics are an automatic decline.)

Have you been prescribed medication that you aren't currently taking? ______________

Please Explain ______________

Please list medications you are currently taking. (Please include over-the-counter medications that are **used daily**)

Name of Medication	Dosage	Condition	Start Date of Medication

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