BackNine Insurance

QUICK QUOTE FOR HEPATITIS (ELEVATED LIVER FUNCTIONS)

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

CLIENT: NAME _____ / ❑ M ❑ F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ❑ UL ❑ TERM YRS. LVL _____

TOBACCO USE ❑ NO ❑ YES, TYPE _____ / REPLACEMENT? ❑ YES ❑ NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

FAMILY HISTORY: AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____

DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK ❑ NO ❑ YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____/_____ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. LIST DATE AND RESULTS OF THE CLIENT'S TWO MOST RECENT LIVER FUNCTION TESTS:

	RESULT	DATE#1	RESULT	DATE#2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. CHECK TYPE, THEN LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

❑ A DATE _____ ❑ NEG ❑ POS

❑ B DATE _____ ❑ NEG ❑ POS

❑ C DATE _____ ❑ NEG ❑ POS

3. HAS THE CLIENT HAD A LIVER BIOPSY?

❑ NO ❑ YES, PLEASE DETAIL DATE AND RESULTS:

_____

_____

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH:

FATTY LIVER? ❑ NO ❑ YES, PLEASE DETAIL:

_____

HEPATITIS? ❑ NO ❑ YES, CHECK TYPE, THEN DETAIL:

❑ ACUTE ❑ CHRONIC ACTIVE ❑ CHRONIC PERSISTENT
DETAILS: _____

CIRRHOSIS? ❑ YES ❑ NO

5. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

❑ NO ❑ YES, PLEASE DETAIL FREQUENCY AND AMOUNT:

_____

IF NO, DATE OF LAST DRINK: MONTH _____ YEAR _____

6. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

❑ 0 TO 6 MONTHS AGO
❑ 6 TO 12 MONTHS AGO
❑ 12 TO 24 MONTHS AGO
❑ OVER 2 YEARS AGO

7 LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

_____

_____