

BackNine Insurance

QUICK QUOTE FOR HYPERTENSION (HIGH BLOOD PRESSURE)

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) _____
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. PLEASE DETAIL THE CLIENT'S FAMILY HISTORY: (AGE IF LIVING / AGE AT TIME OF DEATH AND CAUSE)

FATHER: _____ / _____

MOTHER: _____ / _____

SIBLING: _____ / _____

SIBLING: _____ / _____

2. DETAIL THE CLIENT'S MEDICAL HISTORY (CHECK ALL THAT APPLY):

- CANCER HISTORY
- HEART HISTORY/CONDITION
- DIABETES HISTORY
- ALCOHOL OR DRUG ABUSE HISTORY
- HIGH BLOOD PRESSURE, PLEASE DETAIL:

CURRENT READING _____ / HIGHEST READING _____

TYPE OF TREATMENT _____

- ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING _____ / HDL READING OR RATIO _____

HIGHEST CHOLESTEROL READING _____

TYPE OF TREATMENT _____

- ELECTROCARDIOGRAM (EKG), IF TAKEN WITHIN PAST YR.:

RESULTS: NORMAL OTHER _____

- STRESS EKG OR THALLIUM, IF TAKEN WITHIN PAST YEAR:

RESULTS: NORMAL OTHER _____

- SIGMOIDOSCOPY, IF TAKEN WITHIN PAST YEAR:

RESULTS: NORMAL OTHER _____

- PROSTATE EXAM, IF TAKEN WITHIN THE PAST YEAR:

RESULTS: NORMAL OTHER _____

- MAMMOGRAM, IF TAKEN WITHIN THE PAST YEAR:

RESULTS: NORMAL OTHER _____

2. HEIGHT _____ / WEIGHT _____

WEIGHT LOSS IN LAST YEAR _____

LAST MEASURED BODY FAT % _____ DATE _____

MEN ONLY: CHEST SIZE _____ IN. / WAIST SIZE _____ IN.

3. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP WITHIN THE PAST YEAR?

- NO YES, PLEASE DETAIL RESULTS:

NORMAL OTHER _____

4. 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:

