



Core Income Advisors
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-
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Quick Quote

Agent information

To obtain a tentative offer, the following information must be completed on this cover sheet and medical and/or financial documents submitted.

Agent name: _____ Agent phone: _____

Agent email: _____ Firm name: _____

Agent fax: _____ Contact name: _____

Total pages sent: _____

Client information

Client name: _____ Client SSN: _____

Client DOB: _____ Height: _____ Weight: _____ Gender: Male Female

Product: Term Permanent Face amount: \$ _____

Currently using tobacco? Yes No Client's net worth: \$ _____

Does client participate in any hazardous activities Yes No
If yes, please describe: _____

Does client have any plans for foreign travel? Yes No
If yes, please describe: _____

Has this client ever been rated or declined? Yes No
Note: Clients who have been previously declined by more than two carriers will not be eligible to receive an offer.
If yes, please describe: _____

Total amount applied for with all carriers (include known offers): _____

Total amount of in-force coverage (include all settled policies): _____

Will the insurance be premium financed? Yes No

Please list ALL medications (prescribed or over the counter) and dosages you are currently taking or have taken in the last 30 days? (If none, please state none.)

- | | Medication/Prescription: | Dosage: |
|----|--------------------------|---------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

Medical information

1. Have you ever had symptoms of, been diagnosed with, or been treated for:

- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? Yes No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? Yes No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? Yes No
- d. Diabetes, thyroid, glandular or endocrinal disorder? Yes No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? Yes No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? Yes No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? Yes No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? Yes No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? Yes No
- j. Anemia, hepatitis, or any blood disorder? Yes No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? Yes No

2. Within the last five years, other than as noted above, have you:

- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? Yes No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? Yes No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? Yes No
- d. Do you currently use alcoholic beverages? Yes No
If yes, what is the average number of drinks per day? 2 or less 3-5 6 or more

Give complete details of any YES answers to questions 1 and 2. (If necessary, use an additional page for additional details.)

Question number	Date	Details, include diagnosis, treatment, duration, result	Name, address and phone number of doctor / medical facility

All quotes are tentative, non-binding and subject to change after a complete underwriting workup.

