HEALTH AND LIFE INSURNACE QUESTIONAIRE

FAX REQUEST TO: (704)862-7222

EMAIL REQUEST TO: thecardone@bellsouth.net

1) NAME(S):_____

2) ADDRESS(S): _____

3) DOB(S): _____

4) SSN(S): _____

5) TOBACCO USAGE: YES / NO TYPE/AMOUNT: _____

6) HEIGHT: _____ WEIGHT: _____ BMI: _____

7) DIABETES: YES / NO TYPE: _____ A1C: _____

8) PRIMARY CARE PHYSICIAN (NAME/ADDRESS/PHONE NUMBER)

_____

_____

_____

9) MEDICATIONS TAKEN/DOSAGE REQUIREMENTS/TIMES PER DAY:

_____

_____

_____

10) WHAT DEDUCTIBLE WOULD YOU LIKE? _____

11) AMOUNT OF DEATH BENEFIT (LIFE INSURANCE): _____

12) TYPE OF LIFE INSURANCE REQUESTED:

TERM WHOLE LIFE UNIVERSAL LIFE GUARANTEED OTHER

13) CURRENT HEALTH/LIFE INSURANCE COMPANY: _____