

BEST VALUE INSURANCE AGENCY, INC.

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Life Insurance Intake

Marketer Name: _____ Client Name: _____

Agent Name: _____ Applicants Name: _____

DOB: ____/____/____ Height: _____ Weight: _____ Desired coverage amount: \$ _____

Term Desired: _____ Return of Premium Rider? Yes No

1) Do you use tobacco products: Yes No Type: _____

Used tobacco in past 12 months: Yes No How much? _____

2) Have you previously been declined for life insurance? Yes No Reason: _____

3) Are you receiving Worker's Compensation/Disability? Yes No Reason: _____

Type of Disability Income: _____

4) Actively working? Yes No If no, please explain: _____

5) Does the client have any family history of death before age 65 due to cardiovascular, cerebral vascular disease, diabetes, or cancer? Yes No If yes, explain: _____

6) Within the last 5 years, has the client had a moving violation, reckless driving, or DUI/DWI? Yes No
If yes, explain: _____

7) Any prior convictions? If so, please explain: _____

8) Does the client participate in any dangerous activities/occupations (scuba diving, racing, skydiving, private pilot, etc.)? If so, explain: _____

9) Is the client intending to travel to any foreign country (excluding Canada)? Yes No

If yes, please explain including length of stay: _____

10) U.S. Citizen Yes No Green Card Yes No Applying for Citizenship Yes No

Recent Health History Profile

1) What is your systolic blood pressure level? _____ I don't know

2) What is your diastolic blood pressure level? _____ I don't know

3) What is your cholesterol level? _____ I don't know



HEALTH • LIFE • SENIOR PRODUCTS
ANNUITIES • RETIREMENT ACCOUNTS



9\Life Pre-Qualification
Intake.doc
10/14/2005

Check any condition that applies to your medical history within the last 5 years:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anxiety or Depression |
| <input type="checkbox"/> Artery (Coronary) Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Pressure Medication |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol Medication | <input type="checkbox"/> Colitis or Ileitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Drug Abuse or Addiction | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Gastric/Peptic Ulcers | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Hypertension Medication | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neurogenic Bladder | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Recurrent Kidney Stones | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Organ Transplants | <input type="checkbox"/> Cardiovascular Disease |

If you checked any of the previous conditions, provide full details here.

Diagnosis: _____ Date: _____
Treatments: _____ Prognosis: _____
Medications: _____

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Treatments: _____ Prognosis: _____
Medications: _____

Give details on any surgery or procedure. (i.e. angioplasty, bypass surgery, pacemaker, defibrillator)

Procedure: _____ Date: _____
Treatment or Therapy: _____
Residual Problems: _____

List all prescription medications taken over the past 12 months

1. Medication: _____ Amount: _____:_____ Currently Taking? _____
How Long Taking: _____ Reason Prescribed: _____
2. Medication: _____ Amount: _____:_____ Currently Taking? _____
How Long Taking: _____ Reason Prescribed: _____
3. Medication: _____ Amount: _____:_____ Currently Taking? _____
How Long Taking: _____ Reason Prescribed: _____
4. Medication: _____ Amount: _____:_____ Currently Taking? _____
How Long Taking: _____ Reason Prescribed: _____

**List additional medications, diagnosis, or procedures
on the additional page provided.**

Typical Health Concerns and Medications for Life Insurance Prospects

Asthma

1. Frequency of attacks or hospitalizations?
2. Any oral steroids including inhalers that are steroidal?
3. Smoker?
4. Stable pulmonary function tests?
5. Any diagnosis of COPD or emphysema?
6. How long diagnosed?

Cancer

1. Where cancer originated?
2. What stage of cancer, 1-4? 4 being metastasis and uninsurable.
3. What kind of treatment and last date of treatment if fully recovered (including surgery, radiation, or chemotherapy)?
4. When diagnosed?
5. PSA for prostate cancer <1?
6. If melanoma need Clark level and depth of invasion

COPD/Emphysema

1. What medications, inhalers, and nebulizer?
2. Does the client smoke?
3. Need to know if the client has stable pulmonary function tests?
4. Any hospitalizations?
5. Any limitations or shortness of breath?
6. Any oxygen use, daily steroid use or hospitalizations?
7. When diagnosed?

Crohn's disease

1. When diagnosed?
2. What treatment or meds is the client using?
3. How frequent are flare-ups or hospitalizations?
4. Wt stable?

Diabetes

1. What type, 1 or 2?
2. When diagnosed?
3. How well controlled, last hemoglobin A1C?
4. Any diabetic complications (neuropathy – nerve Damage), retinopathy (eye), nephropathy (kidney Damage), or circulatory problems?
5. Wt and ht stable and w/in the guidelines?
6. What medications, oral or insulin?
7. Any heart conditions?

Heart Disease

1. Any heart surgeries, when and what type, bypass (# of bypasses), angioplasty, pacemaker, or heart valve replacement?
2. Recovered?
3. What medications taking?
4. Any congestive heart failure/atrial fibrillation/heart attack/chest pains.
5. Is the client having regular follow-ups and/or testing (last seen and test results)

Lupus

1. What type? Discoid or systemic?
2. When diagnosed?
3. If systemic, what organs affected and how severe are they affected?
4. What treatment or meds is the client using?
5. How many flare-ups or hospitalizations?

Stroke/CVA/TIA

1. How many strokes?
2. When was the episode?
3. Any residuals, such as numbness, weakness, pain, slurred speech, or visual impairment?
4. Any limitations that require cane or assistance?
5. Any findings on a CT of white matter changes, small vessel disease, ischemic changes, micro vascular changes and lacunar infarcts?
6. Any cognitive abnormalities?

Sleep Apnea

1. When diagnosed?
2. Severity of the condition?
3. Does the client use a CPAP machine? Is the machine hooked to oxygen? If it is then companies will decline.
4. Any other treatment?
5. Stable pulmonary function tests?

