LFS INSURANCE SERVICES

360-694-1612

Life Insurance Quote Request

Email: TBunn@LFSUS.com
Fax: 360-694-4007

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

PRODUCER INFORMATION

Producer: _____ Date Needed: _____
Face Amount: _____ Product: _____
Optional Riders: _____ Chronic /LTC: _____

PROPOSED INSURED INFORMATION

Applicant Name: _____ ☐ Male ☐ Female DOB: _____
State: _____
Premium Tolerance/Offer needed to place: _____

INSURANCE CURRENTLY IN FORCE

Company	Year Issued	Face Amount	Being Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No

ACTIVITY AND MEDICAL INFORMATION

Do you participate in any hazardous activities? ☐ Flying ☐ Scuba ☐ Climbing ☐ Other
Details: _____

Do you have any plans for foreign travel? ☐ Yes ☐ No
Details: _____

Have you ever used any kind of marijuana or tobacco product? ☐ Yes ☐ No
Tobacco: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Vape
Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Last Use _____
Marijuana: ☐ Yes ☐ No _____
Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Recreational _____

Height: _____ Weight: _____

ACTIVITY AND MEDICAL INFORMATION, CONTINUED

Do you have a history of:
High Blood Pressure ☐ Yes ☐ No
Heart Condition/Coronary Artery Disease ☐ Yes ☐ No
☐ Heart Attack ☐ Bypass Surgery Date of event: _____
☐ Stent(s) Date of Last EKG/Stress Test: _____

Diabetes ☐ Yes ☐ No

At what age were you diagnosed? _____

List all diabetes medications currently prescribed:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Most recent A1c level: _____ Current glucose reading: _____

Respiratory Disease ☐ Yes ☐ No

Have you been hospitalized for this condition: ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you curently using a CPAP? ☐ Yes ☐ No

Date of last pulonary function test: _____

Cancer ☐ Yes ☐ No

Type of cancer: _____

Was there a biopsy? ☐ Yes ☐ No Cancer stage if known: _____

Date of surgery, if any? _____

Date of completion of radition treatment: _____

Date of competion of chemotherapy: _____

Please list any medical conditions not indicated above:

FAMILY MEDICAL HISTORY

Family Member	Age If deceased, age @ death and cause	History of Heart Disease?		History of Cancer?		Type
Mother		☐ Yes	☐ No	☐ Yes	☐ No	
Father		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 1		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 2		☐ Yes	☐ No	☐ Yes	☐ No	

ADDITIONAL NOTES

_____

_____

_____

_____

_____

LFS INSURANCE SERVICES