M. WILLIAMSON
INSURANCE SERVICES
LIFE INSURANCE | DISABILITY INSURANCE | LONG-TERM CARE INSURANCE

10380 SW Village Center Dr., #406
Port St. Lucie, FL 34987
T: 631-730-8262
F: 866-275-7847
mbwinsurance.com

INFORMAL INQUIRY

Not an application for life insurance

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

PRODUCER INFORMATION

Producer: ____________ Date: ____________

Face Amount: ____________ Product: ____________

PROPOSED INSURED INFORMATION

Applicant Name: ____________ ☐ Male ☐ Female DOB: ____________

SS#: ____________ Drivers License #: ____________

Street Address: ____________

City: ____________ State: ____________ Zip Code: ____________

Primary Phone Number: ____________ ☐ Home ☐ Work ☐ Mobile

Alternate Phone Number : ____________ ☐ Home ☐ Work ☐ Mobile

Occupation: ____________ Income: ____________

Assets: ____________ Liabilities: ____________ Net Worth: ____________

Premium Tolerance/Offer needed to place: ____________

Can you provide Third Party Financials signed by a currently licensed CPA? ☐ Yes ☐ No

INSURANCE CURRENTLY IN FORCE

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

Forms Used: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ____________

Date last used: ____________

Do you have any knowledge that an application or informal inquiry has been seen by any carrier in the last year?

☐ Yes
☐ No

Company	Offer	Placed?

Height: ____________ Weight: ____________

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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: ______

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	

SENIOR SUPPLEMENT

Have you been diagnosed with Alzheimer's or dementia? ☐ Yes ☐ No

Have you ever been treated for memory problems? ☐ Yes ☐ No

Do you require assistance for walking? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Do you exercise on a daily basis? ☐ Yes ☐ No

Do you require assistance with daily chores? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been diagnosed with depression? ☐ Yes ☐ No

Have you ever been diagnosed with anemia? ☐ Yes ☐ No

Please provide details of any "Yes" answers above: ______

______

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SENIOR SUPPLEMENT, CONTINUED

Please list all medications being taken: ______________________

____

PHYSICIAN INFORMATION

Physician Name: ______________________ Phone: ______________

Address: ______________________

Date last seen: __________ Reason: ______________________

Physician Name: ______________________ Phone: ______________

Address: ______________________

Date last seen: __________ Reason: ______________________

PHYSICIAN INFORMATION, CONTINUED

Physician Name: ______________________ Phone: ______________

Address: ______________________

Date last seen: __________ Reason: ______________________

Physician Name: ______________________ Phone: ______________

Address: ______________________

Date last seen: __________ Reason: ______________________

ADDITIONAL NOTES