Return to - jim@uswolfe.com or Fax to 815-377-3556

Policy Number:_____ Date:_____

Life Insurance General Purpose Request & Questionnaire

Name:_____

Male Female

D.O.B.: _____/_____/_____

Height: _____ Weight:_____

Tobacco User? Yes No

Type: _____

Insurance Amount:_____

Insurance Type: UL WL Term

1) Please list any and all illnesses:

_____

_____

_____

Provide details to #1:

_____

_____

_____

_____

_____

_____

2) Please provide month and year illness was diagnosed. _____/_____

3) What type of treatment was administered?

Surgery month/year _____/_____

Physical Therapy

Medications (please list kind and dosage)

_____

_____

Other type(s) of treatment (Please explain)

_____

_____

_____

4) When was the last time you visited a physician? And why?

0 to 6 months ago

6 to 12 months ago

12 to 24 months ago

over 24 months ago

_____

_____

5) Last known cholesterol reading? _____

6) Last known blood pressure reading?

_____/_____

7) Do you regularly exercise 3 or more times per week?

Yes (type) _____

No

8) Please list all other impairments:

_____

_____

9) Please list all medications currently being taken.

_____

_____

_____

_____

_____

10) Has either parent, or any sibling, died before the age of 65, other than by accident?

Mother Father Sibling

Cause:_____

11) Have you applied for life insurance with any other carriers? Yes No

Company Name: _____

Date: _____/_____/_____

Result: Preferred Standard

Declined Postponed

Rated Table_____

Additional Comments:

_____

_____

_____

_____

Agent: _____

Agent Address:

_____

_____

_____

Agent Phone#: _____

Agent Fax#: _____

Agent Email:_____

Agent Signature: _____