Brown & Brown
ASSOCIATES, P.C.
We do more for you

FAX 877/747-4445 OR 361/993-2734 PHONE 800/747-4445 OR 361/993-3820

IMPAIRED RISK QUESTIONNAIRE

Submit the specific questionnaire for each of your client's health impairments.
Provide as much detail as possible in order to obtain the best offer.

Contact Person: **ALTA GARCIA (alta@brownbrown-assoc.com)**

Date _____ Agent's Name: _____ STATE_____

Agent's E-mail (provide only if you want to receive communications via email):
_____

Agent Phone #: _____ Agent Fax #:_____
How do you wish to be contacted with offer: __Email __Fax __Phone

Applicant's Name:_____ DOB:_____/_____/_____

Face Amount $_____ TERM: ___5 ___10 ___15 ___20 ___30 __ UL
Maximum Premium Acceptable $_____
Premium mode: __Annual __Semiannual __Quarterly __Monthly

__MALE __FEMALE Is client a US Citizen? _____

QUESTIONS FOR POTENTIAL CLIENTS

Height:_____' ____" Weight:_____lbs Cholesterol level_____ HDL_____

Does client use tobacco in any form? _____ No ____Yes Type?_____
Has client ever used any form of Tobacco? _____ No ____Yes Type?_____
Quantity per week?_____ Date when use was terminated?_____

Has client been rated? _____ ***If yes, list companies, dates, reasons, how rated and premium amount offered***
_____
Has client been declined for life insurance? ____ ***If yes list companies, dates, reason***
_____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide? (Please show age at onset and date of death) use separate sheet if necessary
_____.

PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is policy to be Replaced?