**INFORMAL INQUIRY**

This form is used to review insurance opportunities and is *not* an application for life insurance. Incomplete information can lead to an inaccurate assessment from insurance carriers. Please email the completed form to newbusiness@idesign-network.com.

IDN INSURANCE DESIGN NETWORK LLC

## Producer & Product Information

Producer Name: _____ Date: _____

Product Description: _____ Face Amount: _____

## Proposed Insured Information

Applicant Name: _____ ☐ Male ☐ Female DOB: _____

SS#: _____ Height: _____ Weight: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ US Citizen: ☐ Yes ☐ No

Annual 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

## In Force Policy Information

Please List all current insurance policies that are in force:

| Company | Year | Face Amount | Being Replaced? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

Do you have knowledge of an application or inquiry being sent to any carrier in the last year? ☐ Yes ☐ No

| Company | Offer Amount | Placed? |
|---|---|---|
| | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No |

## Activity and Medical Information

Do you participate in any hazardous activities? ☐ Yes ☐ No (*if yes, please complete below section*)

☐ Flying ☐ Scuba ☐ Climbing ☐ Other _____

Details: _____

Do you have any plans for foreign travel? ☐ Yes ☐ No (*if yes, please complete below section*)

Details: _____

Have you ever used any kind of tobacco product? ☐ Yes ☐ No (*if yes, please complete below section*)

Forms used: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Other _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Date last used: _____

## Activity and Medical Information *(continued)*

Do you have a history of the following:

High Blood Pressure: ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease: ☐ Yes ☐ No

(*if yes, please complete below section)*

☐ Heart Attack ☐ Bypass Surgery ☐ Stent(s)

Date of event:_____ Date of Last EKG/Stress Test:_____

Diabetes: ☐ Yes ☐ No (*if yes, please complete below section)*

At what age were you diagnosed?_____

Most recent A1c level:_____ Current glucose reading: _____

List all diabetes medications currently prescribed:

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Respiratory Disease: ☐ Yes ☐ No (*if yes, please complete below section)*

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

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

Are you currently using a CPAP: ☐ Yes ☐ No

Date of last pulmonary function test:_____

Cancer: ☐ Yes ☐ No (*if yes, please complete below section)*

Type of cancer:_____

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

Date of surgery, if any: _____

Date of completion of radiation treatment: _____

Date of completion of chemotherapy:_____

Please list any medical conditions not indicated above:_____

_____

_____

## Family Medical History

| Family Member | History of Heart Disease | History of Cancer | Type of Cancer |
|---|---|---|---|
| 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 daily? ☐ 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:

_____

_____

_____

_____

_____

_____

Please list all current medications:

_____

_____

_____

_____

## Physician Information

Physician Name:_____

Phone:_____

Address:_____

Date last seen:_____ Reason:_____

Physician Name:_____

Phone:_____

Address:_____

Date last seen:_____ Reason:_____

Physician Name:_____

Phone:_____

Address:_____

Date last seen:_____ Reason:_____

Physician Name:_____

Phone:_____

Address:_____

Date last seen:_____ Reason:_____

## Additional Information

Please list any additional information that would pertain to applying for an insurance policy:

_____

_____

_____

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