Informal Inquiry

NOT AN APPLICATION FOR LIFE INSURANCE

USA UNDERWRITING SERVICES OF AMERICA
3160 Camino Del Rio South
Suite, #313
San Diego, CA 92108
www.usa-bga.com

Date: _____ **PRODUCER:** _____
Face Amount: _____ Product Type: _____

Applicant: _____ ☐ Male ☐ Female DOB: _____
SS#: _____ Driver's License #: _____ Place of Birth: _____
Address: _____ City: _____ State: _____
Zip: _____ Home Phone: _____ Occupation: _____ How Long: _____
Income: _____ Assets: _____ Liabilities: _____ Net Worth: _____
Premium Tolerance/Offer needed to place: _____

Has the Owner/Insured ever sold an insurance policy? ☐Yes ☐ No If so, when?_____

Will this case be premium financed? ☐ Yes ☐ No If so, program considered?_____

Can you provide 3rd party financials signed by a currently licensed CPA? ☐Yes ☐ No

Insurance Currently In Force:

Company	Year Issued	Face Amount	Replace?	Offer to be Replaced

Do you participate n any hazardous activities? ☐ **Flying** ☐ **Scuba Diving** ☐ **Mountain Climbing** ☐ **Other**_____
Do you have any plans for foreign travel? (If yes, please advise when, where, purpose and how long)

_____

Have you ever used any kind of tobacco or any other products containing nicotine? ☐Yes ☐ No

If yes, please indicate which form: ☐ cigarette ☐ pipe ☐ nicotine gum/patch
☐ cigar (how many per year) _____ ☐other _____

Has use been discontinued? ☐Yes ☐ No Date discontinued: _____

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

☐ Yes ☐ No

Carrier	Offer	Decline
		☐
		☐
		☐

Height: _____ Weight: _____
Do you have a history of:

High Blood Pressure? ☐Yes ☐ No What medications were you taking? _____

_____

Heart condition/Coronary Artery Disease? ☐Yes ☐ No When did the event occur? _____

☐ Heart Attack ☐ Bypass ☐ Stent (s) How many Vessel's affected? _____ Last EKG/Stress Test? _____
Name and address of physicians that treat you:

_____

Diabetes? ☐ Yes ☐ No ☐ Type1 ☐ Type2 At what age were you first diagnosed? _____
List medications being taken: _____ Last A1C numbers? _____
Last Glucose readings? _____
What is the therapy and doses at present time?_____

Check box for any complications: ☐ Kidneys ☐ Peripheral vascular disease ☐ Neuropathy ☐ Retinopathy
Name and address of physicians that treat you: _____

_____

Respiratory Disease? ☐Yes ☐ No Check appropriate box: ☐ Asthma ☐ COPD

Have you ever been hospitalized? ☐Yes ☐ No Have you ever been diagnosed with Sleep Apnea? ☐Yes ☐ No

Currently using CPAP? ☐Yes ☐ No Date: _____ Last Pulmonary Function Test? _____
Name and address of physicians that treat you: _____

Arthritis? ☐Yes ☐ No **Type?** _____
Name and address of physicians that treat you: _____
_____

Cerebral Vascual Accident? ☐Yes ☐ No Type of Event: ☐ Stroke ☐ TIA Date of Event: _____
Name and address of physicians that treat you: _____
_____

Cancer? ☐Yes ☐ No When/where were you diagnosed with cancer? _____
What physicians would have the pathology report? _____ _____
Was there a biopsy? ☐Yes ☐ No What is the stage of the cancer? _____
What are the dates of radiation or chemotherapy? ____ _____
Name and address of physicians that treat you: _____

Family Health History:	**Age** *(If deceased, age at death*	**History of Heart Disease**	**History of Cancer***(All Types)*
Mother			
Father			
Sister(s)			
Brother(s)			

List any medical conditions not indicated above: _____
_____
_____

Senior Supplement 70+

Have you ever been diagnosed with Alzheimers or Dementia? ☐Yes ☐ No

Have you ever been tested for memory problems? ☐Yes ☐ No
What medications are you currently on? _____

Do you require assistive devices for walking? ☐Yes ☐ No

Do you have a history of falls? ☐Yes ☐ No If so, please explain: _____
_____

Do you excercise on a daily basis? ☐Yes ☐ No If yes, how many hours? _____

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
Details: _____

Physician Information:

Please list all physicians seen within the past ten (10) years:

Physician Name: _____ Phone: _____
Address: _____
Date Last Seen: _____ Reason: _____

Physician Name: _____ Phone: _____
Address: _____
Date Last Seen: _____ Reason: _____

Physician Name: _____ Phone: _____
Address: _____
Date Last Seen: _____ Reason: _____

Please use an additional page, if necessary.