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Stafford, Texas 77477
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Life Quote Request Form

Client Information

First Name:	
Last Name:	
E-mail:	
Home Phone Number:	
Cell Phone Number:	
Fax Number:	
Preferred contact method	○ Phone ○ Fax ○ Mail ○ E-mail
If by phone, the best time to call.	○ AM ○ PM
Address:	
City:	
State:	
Zip code:	
Occupation:	
Date of birth:	
Sex:	
Height:	
Weight:	

Are you a citizen of the United States?	○ Yes ○ No
Have you lived outside the United States during the last 3 years?	○ Yes ○ No
Do you plan to leave the United States for travel or residence during the next 3 years?	○ Yes ○ No

Please list the foreign countries that you are planning to visit / reside:	
Do you currently work in a hazardous occupation?	
Do you participate in any risky outdoor activities?	◯ Yes ◯ No
Do you fly as a pilot, co-pilot or crewmember of an aircraft?	◯ Yes ◯ No
Are you an active member of the military or military reserve?	◯ Yes ◯ No
Have you received three or more moving violations or had your driver's license suspended/revoked in the past 5 years?	◯ Yes ◯ No
Have you been found guilty of reckless driving or driving under the influence (DUI/DWI)?	◯ Yes ◯ No
When was the last time that you used any type of tobacco product or nicotine substitute?	
Is there any family history of cardiovascular disease before the age of 60?	◯ Yes ◯ No
Have you had any health symptoms or been treated for any of the conditions listed below? (If Yes, please check those below which apply)	◯ Yes ◯ No

☐	AIDS & AIDS related	☐	Epilepsy	☐	Liver disease	☐	Psychiatric disorders
☐	Alcoholism	☐	Fatigue disorders	☐	Lupus	☐	Rheumatoid arthritis
☐	Alzheimer's	☐	Heart Disease/ Bypass Surgery	☐	Lymphoma	☐	Seizure disorders
☐	Asthma	☐	High blood pressure	☐	Manic depression	☐	Spinal disc disorders
☐	Breast cancer	☐	HIV	☐	Melanoma	☐	Stroke
☐	Chronic bronchitis	☐	Infertility	☐	Multiple sclerosis	☐	Substance abuse
☐	COPD	☐	Joint replacement	☐	Muscular dystrophy	☐	TIA
☐	Diabetes	☐	Kidney stones	☐	Other demyelinating disorders	☐	Ulcerative colitis
☐	Emphysema	☐	Leukemia	☐	Peripheral vascular disease	☐	Uterine disorders

Do you have cancer? ◯ Yes ◯ No

If yes, specify cancer details here:

Please list all medications your currently take:

Coverage amount?

Desired term period?