

# Advisor Insurance Resource

(866) 942-4181 • Fax (866) 810-9415

## Client Health History

Advisor \_\_\_\_\_ Advisor Phone \_\_\_\_\_

Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Tobacco Use \_\_\_\_\_ Amount \_\_\_\_\_

Day Time Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Best Time to call \_\_\_\_\_

Email Address \_\_\_\_\_ State of Residence \_\_\_\_\_

Occupation \_\_\_\_\_ Annual Income \_\_\_\_\_

Amount of Insurance \_\_\_\_\_ Type of Insurance: \_\_\_\_\_

Do you have Existing Insurance \_\_\_\_\_ Replacing existing insurance \_\_\_\_\_

Family History: (Check all that apply)      Mother                      Father                      Siblings

Cancer < age 60                                                                                                                 

Heart disease < age 60                                                                                                                 

Diabetes < age 60                                                                                                                 

Personal Medical History: (Check all that apply)

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Cancer (any)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> MS
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Counseling	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Allergies	<input type="checkbox"/> Crohn's	<input type="checkbox"/> HIV	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Elevated Blood Pressure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Vascular Disease

Please describe any checked answers above:

Please list all medications taken and/or surgeries in the last five years:

Please list any motor vehicle tickets, bankruptcy's or lawsuits within the last 5-years:

Disclaimer: The information provided on this form is to be used only for the pre-qualification of disability, life, and/or long-term care insurance. The completion of this form does not constitute the application or approval of any insurance. The information provided on this form shall be used only for insurance quoting by Advisor Insurance Resource.