CLIENT QUALIFICATION FORM

GENERAL INFORMATION

Client		Spouse/Other	
Name:		Name:	
Date of Birth:	Age:	Date of Birth:	Age:
Height:	Weight:	Height:	Weight:
Tobacco use? Y or N		Tobacco use? Y or N	

MEDICAL PROBLEMS

high blood pressure | heart condition(s) | sleep apnea | stroke | cancer | diabetes (oral/insulin) | diseases

Client	Spouse/Other

MEDICATIONS

Client	Spouse/Other

OCCUPATIONAL INFORMATION

Client	Spouse/Other
Occupation:	Occupation:
Do you currently have life insurance? Y or N	Do you currently have life insurance? Y or N
If yes, how much coverage? $	If yes, how much coverage? $

MORTGAGE INFORMATION

Loan Amount: $	Mortgage Company:
Mortgage Term:	Monthly Payment:

PRIMARY CONCERN

What do you want this coverage to do for you? What made you want to send this form back to us?