CPS RELIABLE FINANCIAL GROUP

Pre-Quote Questionnaire

All questions contained in this questionnaire are strictly confidential. All confidential information shared in this form will be used for the sole purpose of acquiring life insurance coverage.

Client Name *(Last, First):*		Advisor Name *(Last, First):*
Date of Birth:	**Face Amount Requested:**	**Issue State:**

HEIGHT & WEIGHT

Current Height*:	Current Weight*:	
Have you experienced a weight change of 10 pounds or more in the last 12 months? *	☐ Yes	☐ No
Pounds lost?	Pounds Gained?	
Reason for Change?		

TOBACCO USE

Have you EVER used tobacco in any form, or smoking cessation products (such as e-cigarettes, Nicorette, Chantix, etc)? *	☐ Yes	☐ No
Products used?		
Frequency of use?	Date of Last Use:	

HEALTH HISTORY

Have you ever been diagnosed, received treatment, or consulted a health professional for any of the following? If YES, please check all that apply.

☐ High Blood Pressure	☐ High Cholesterol	☐ Seizures	☐ Alzheimer's Disease	☐ Lupus
☐ Chest Pain	☐ Cancer/Tumor/Polyp	☐ Stroke/TIA	☐ Dementia/Memory Loss	☐ Anemia
☐ Heart Attack	☐ Asthma/Bronchitis	☐ Paralysis	☐ Colitis	☐ Depression/Anxiety
☐ Heart Murmur	☐ Emphysema	☐ Multiple Sclerosis	☐ Hepatitis	☐ Eating Disorder
☐ Diabetes	☐ Sleep Apnea	☐ Parkinson's Disease	☐ Arthritis	

If you checked any of the boxes above, please provide a description that includes the diagnosis, date of diagnosis, treatment and doctor's name and facility where you were diagnosed.

Other than those indicated above, have you EVER had any disease or disorder of any of the following? If YES, please check ALL that apply and provide details below.

☐ Heart	☐ Gastrointestinal Digestive System	☐ Brain/Nervous System	☐ Thyroid/Other Glands	☐ Muscles/Bones/Joints
☐ Arteries/Veins	☐ Kidney/Bladder	☐ Blood	☐ Eyes	☐ Emotional/Psychological Disorder

☐ Lungs/Respiratory System	☐ Prostate	☐ Lymph Nodes	☐ Ear/Nose/Throat	
☐ Liver/Pancreas	☐ Reproductive Organs	☐ Immune System	☐ Skin	

If you checked any of the boxes above, please provide a description that includes the diagnosis, date of diagnosis, treatment and doctor's name and facility where you were diagnosed.

Other than indicated previously, in the past 5 years, have you had any illness, injury, surgery, physical exam, consultation or medical test (ex. Laboratory tests, EKG, etc.), or been a patient in a hospital or other medical facility? *

☐ Yes ☐ No

If yes, please provide a description that includes the diagnosis, date of diagnosis, treatment, and doctor's name and facility where you were diagnosed.

Are you currently receiving any treatment or taking any prescription or nonprescription medications or supplements? *

☐ Yes ☐ No

If yes, please provide a description that includes the diagnosis, date of diagnosis, treatment, and doctor's name and facility where you were diagnosed, and the medication prescribed.

Do you have any surgery, medical test, treatments or visits with a health professional scheduled in the next six months? *

☐ Yes ☐ No

If yes, please provide a description of what is planned and when. Also, include the diagnosis, date of diagnosis, treatment and doctor's name and facility where you were diagnosed.

Have you ever been diagnosed with, are treated by a member of the medical profession, for Acquire Immune Deficiency Syndrome (AIDS), AIDS Human Immunodeficiency Virus (HIV), or the antibodies to the AIDS (HIV) Virus? *

☐ Yes ☐ No

If yes, please provide a description that includes the diagnosis, date of diagnosis, treatment, and doctor's name and facility where you were diagnosed.

Have you ever used cocaine, heroin, or other illicit drugs or controlled substances EXCEPT as prescribed by a health professional?*

☐ Yes ☐ No

If yes, provide the type of substance used, the initial date used, the frequency of use, and the date of last use.

Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs by a health professional or support group? *

☐ Yes ☐ No

If yes, please provide a description that includes the diagnosis, date of diagnosis, treatment, and doctor's name and/or facility where you were diagnosed. Also, provide the date of last use and if you are active with a support group currently.

FAMILY HISTORY

Does your father have any history of cancer, cardiac disease or diabetes prior to age 60? *	☐ Yes	☐ No
If yes, please detail the age he was diagnosed & type of cancer, cardiac disease or diabetes.		
If applicable, age of father's death?	If applicable, cause of father's death:	

Does your mother have any history of cancer, cardiac disease or diabetes prior to age 60? *	☐ Yes	☐ No
If yes, please detail the age she was diagnosed & type of cancer, cardiac disease or diabetes.		
If applicable, age of mother's death?	If applicable, cause of mother's death:	

Do(es) your sibling(s) have any history of cancer, cardiac disease or diabetes prior to age 60? *	☐ Yes	☐ No
If yes, please detail the age of diagnosis & type of cancer, cardiac disease or diabetes.		
If applicable, list the ages and cause of sibling(s) death.		

PERSONAL HISTORY

Within the last five years, have you filed for bankruptcy, or had any judgements or liens filed against you? *	☐ Yes	☐ No
If yes, discharge date:		
Have you ever been convicted of a misdemeanor or a felony?*	☐ Yes	☐ No
If yes, please provide details of charges and conviction:		
Are you currently receiving workers' compensation, social security or disability income?*	☐ Yes	☐ No
If yes, please provide start date and reason:		

TRAVEL HISTORY

Has your driver's license ever been suspended or revoked? *	☐ Yes	☐ No
If yes, please provide details:		
Have you ever been convicted, or plead guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?*	☐ Yes	☐ No
If yes, please provide the month and year of conviction (MM/YYYY):		
In the past 3 years have you had 3 or more speeding tickets?*	☐ Yes	☐ No
If yes, please provide month and year of ticket and the mph over the speed limit you were going:		

Please select any activities you have participated in in the last 3 years, or you plan to engage in in the future.

☐ Ultra-Light Flying	☐ Hot-Air Ballooning	☐ Mountain, Rock or Ice Climbing
☐ Motor Vehicle Racing/Boat Racing	☐ Scuba Diving	☐ Sky Diving

If you have, or plan to, engage in any of the above activities, please provide dates of engagement in the activities and details specific to the avocation including types, heights, speeds, depths, location and your future plans.		
Do you plan to travel outside the United States in the future?*	☐ Yes	☐ No
If yes, please provide details of when (if applicable), what destinations, and the reason for the trip:		

INSURANCE HISTORY

Have you ever had life, health or long term care declined, rated or issued other than you had applied for? *	☐ Yes	☐ No
If yes, please provide the date of, and reason for, the decline:		

*** - indicates required field**

Submit complete form via fax to (509)-822-3297 or via email
to frank@cps-reliable.com