

FSG Medical History Quick Quote

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section A – Personal Information** | | | | |
| Client Name:       M  - F | | Date of Birth: | | |
| Advisor Name: | | Height: | | |
| Firm: | | Weight: | | |
| **Section B – Personal Health History (For “Yes” Answers, please provide details)** | | | | |
| **In the last 10 years, have you been treated for, or diagnosed with (Please Circle):** | | | Yes | No |
| 1 | High blood pressure, heart attack, chest pain, heart murmur, irregular heartbeat, stroke, or any other disease or disorder of the heart or blood vessels?  Most recent blood pressure reading       Cholesterol       Ratio | |  |  |
| 2 | Cancer, tumor, cyst or growth? Type       Date(s)       Stage/Grade | |  |  |
| 3 | Asthma, bronchitis, emphysema, tuberculosis, or any other disease or disorder of the lungs or respiratory system? | |  |  |
| 4 | Seizure, paralysis, headaches, multiple sclerosis, or any other disease or disorder of the brain or nervous system? | |  |  |
| 5 | Chronic fatigue, stress, depression, anxiety, or any emotional or psychological disorder? | |  |  |
| 6 | Hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas, or digestive tract? | |  |  |
| 7 | Diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? Date of Diagnosis       Current A1C       Treatment | |  |  |
| 8 | Kidney stones, nephritis, blood or protein in the urine, HIV, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? | |  |  |
| 9 | Any disease or disorder of the bones, joints, or muscles? | |  |  |
| **Section C – Family and Personal History** | | | | |
| 10 | Have your parents or siblings died from diabetes, cancer, stroke, or heart disease? Age at death | |  |  |
| 11 | Are you **currently** taking any medications? Provide details (Give name of drug, dosage, and reason for taking): | |  |  |
| **Section D – Activities and Health Habits** | | | | |
| **In the last 5 years…** | | | Yes | No |
| 12 | Have you used tobacco in any form (including gum/patch)? Type       Date last used | |  |  |
| 13 | Engaged in any of the following activities: scuba/skin diving, pilot, organized motor vehicle racing, skydiving, hang gliding, mountain climbing, or rodeo? | |  |  |
| 14 | Any future foreign travel plans outside the U.S. or Canada? Provide details in space below. | |  |  |
| 15 | Been in a motor vehicle accident, had a DUI or have more than two moving violations? | |  |  |
| 16 | If answered **YES** to any question 1-15 above please provide details: | | | |

**INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

**LEGAL** NAME:

(FIRST, MIDDLE, LAST)

MALE  FEMALE  DRIVERS LICENSE #:

MARITAL STATUS       STATE:       EXP DATE:

HEIGHT:       WEIGHT:       BIRTH STATE:

HOME ADDRESS:

CITY:       STATE:       ZIP:       # YEARS

PHONE#:       WORK PHONE#:       EMAIL ADDRESS:

DATE OF BIRTH:    /    /

SSN:    -  -     DO YOU USE ANY FORM OF TOBACCO: YES  NO

EMPLOYER:      JOB TITLE:       DUTIES:

WORK ADDRESS:

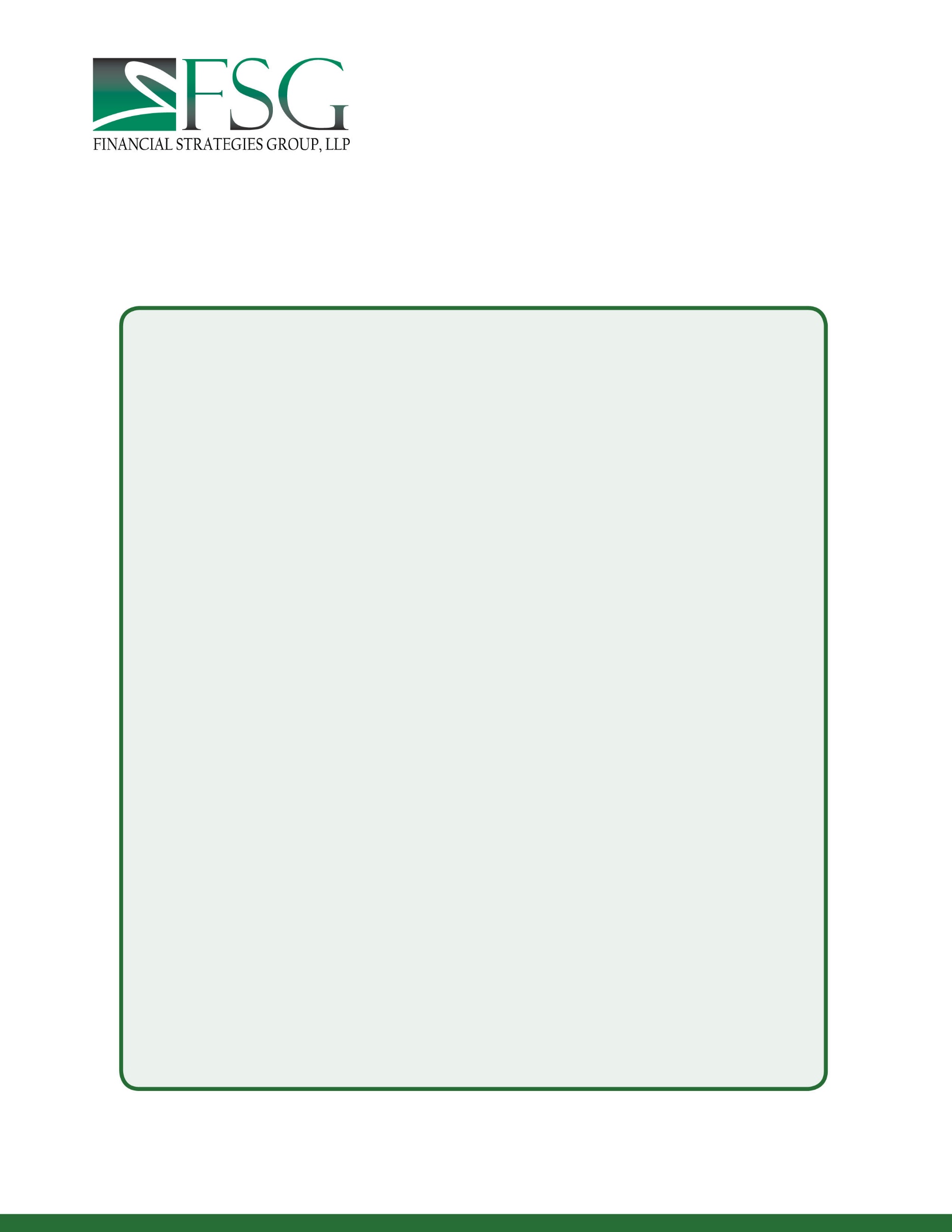
CITY:       STATE:       ZIP:

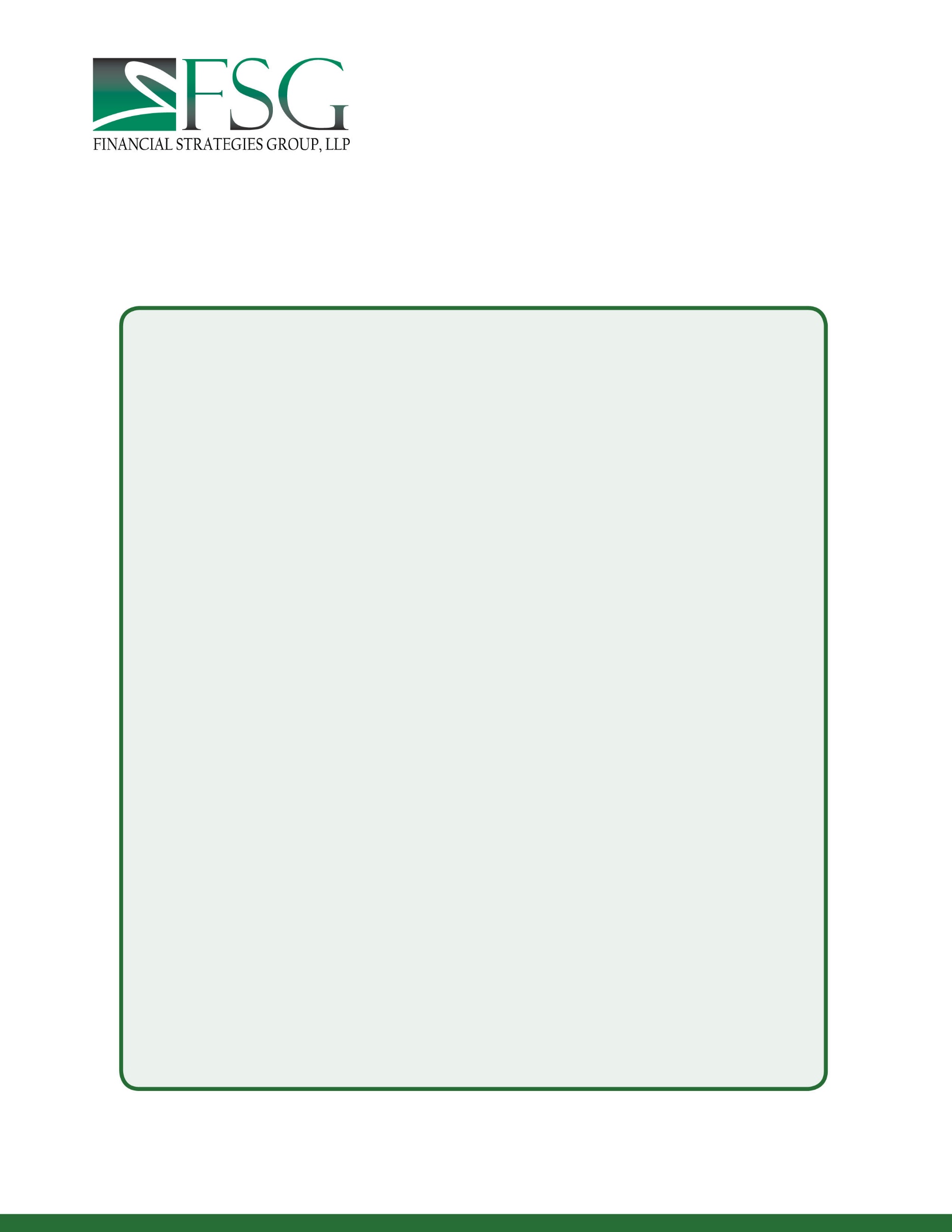
YEARS EMPLOYED AT CURRENT JOB:

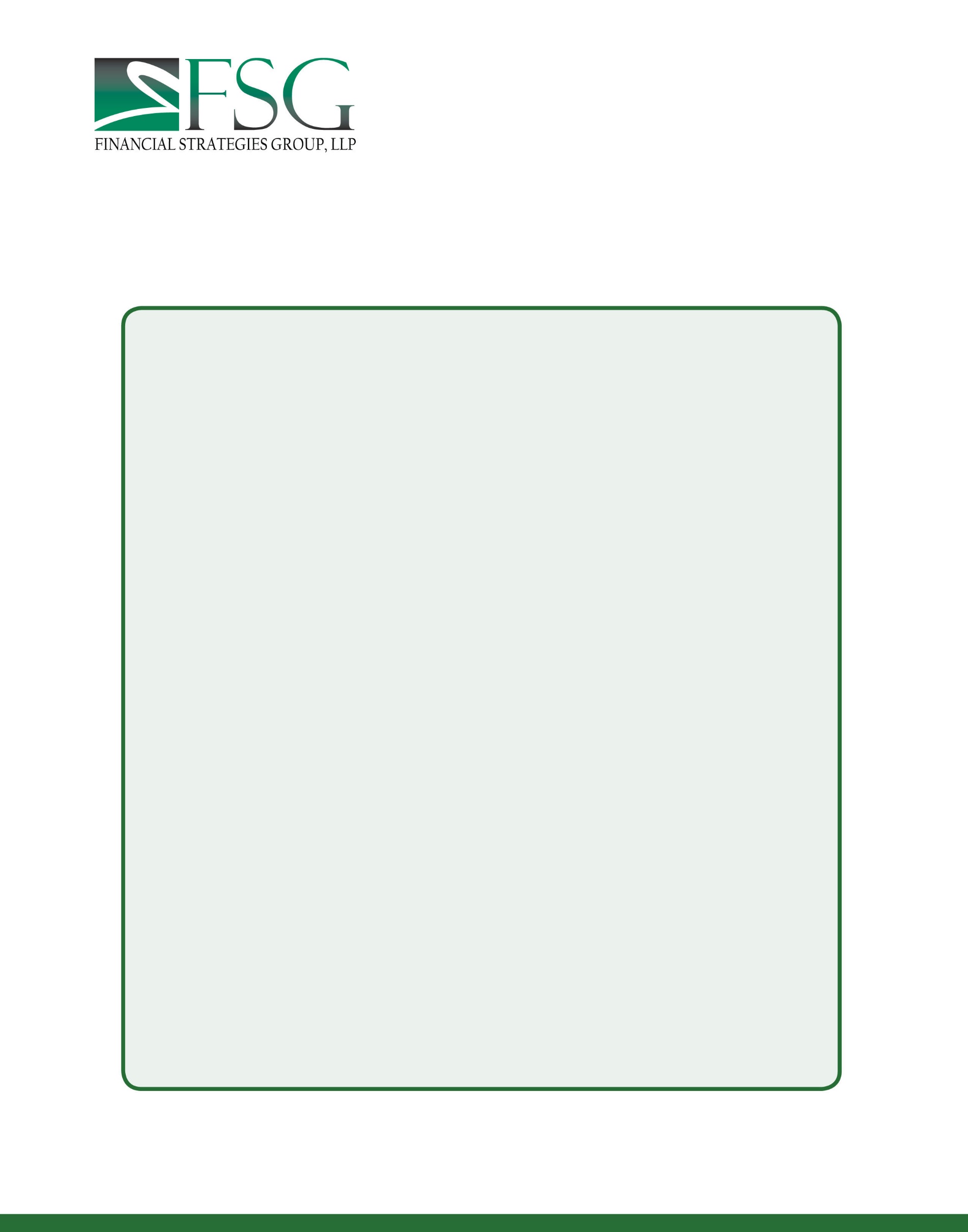
**FAMILY HISTORY**

LIVING OR CAUSE OF DEATH AND AGE

MOTHER:       AGE:       FATHER:       AGE:







**INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

OWNER / IF OTHER THAN INSURED:

SSN OR TAX ID:

DATE OF BIRTH OR TRUST DATE:

TRUSTEE:

ADDRESS:

CITY:       STATE:       ZIP:

RELATIONSHIP TO INSURED:

***IF TRUST OWNED, PROVIDE A COPY OF***

***THE FIRST AND SIGNATURE PAGE OF TRUST***

**HOUSEHOLD FINANCIALS:**

ASSETS:

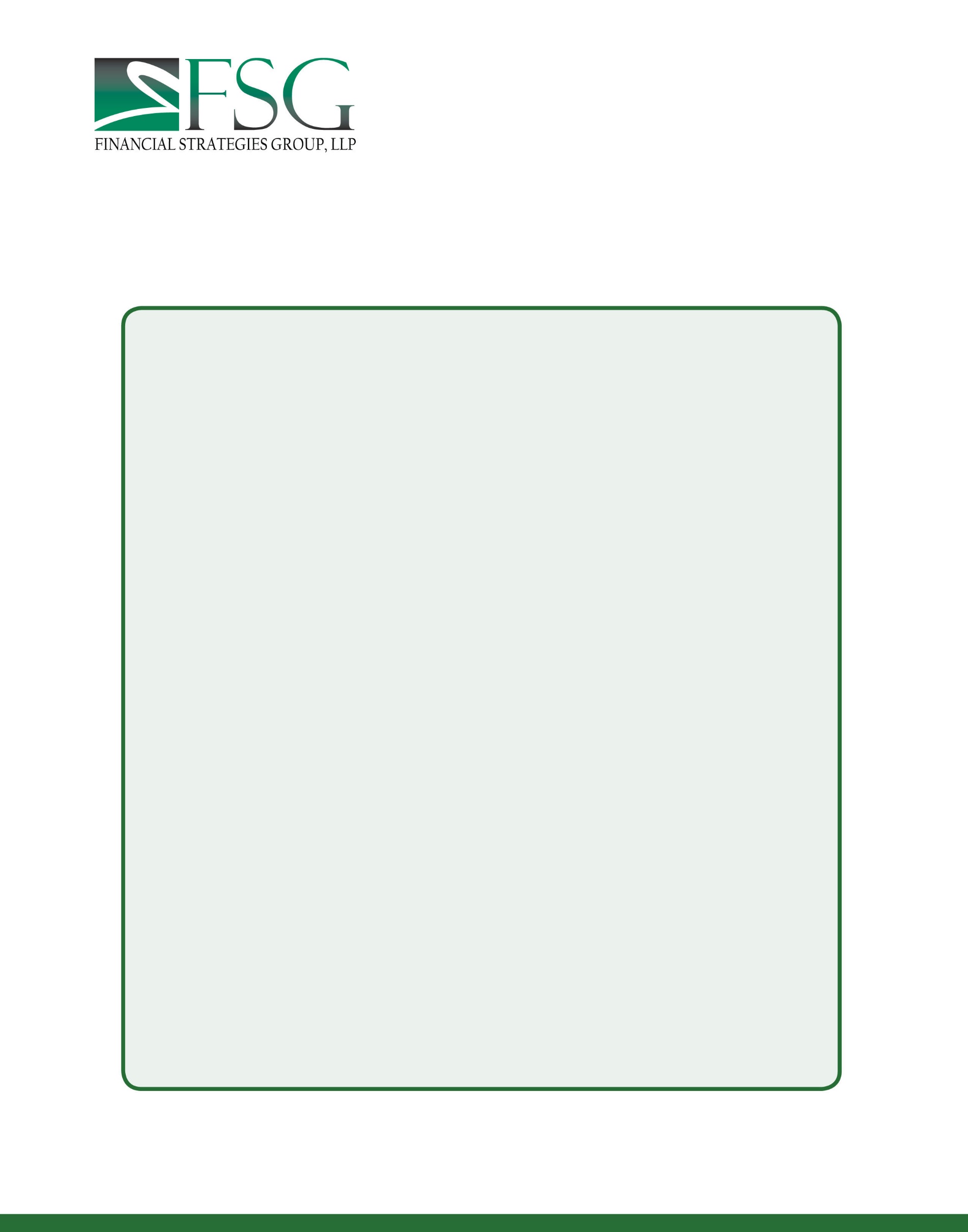
LIABILITIES:

LIQUID ASSETS:

EARNED INCOME:

UNEARNED INCOME:

HOUSEHOLD INCOME:



**INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

BENEFICIARY NAME:       RELATIONSHIP:

BENEFICIARY ADDRESS:

BENEFICIARY SSN:       BENEFICIARY DATE OF BIRTH:

ANY BOOKED TRAVEL PLANNED OUTSIDE USA? YES  NO

IF SO: (BUSINESS OR PLEASURE, DATE, AND DURATION, CITY)

ADVISOR / AGENT NAME:       YEARS KNOWN CLIENT:

ADVISOR / AGENT SSN:    -  -

ANY OTHER LIFE INSURANCE INFORCE? YES  NO

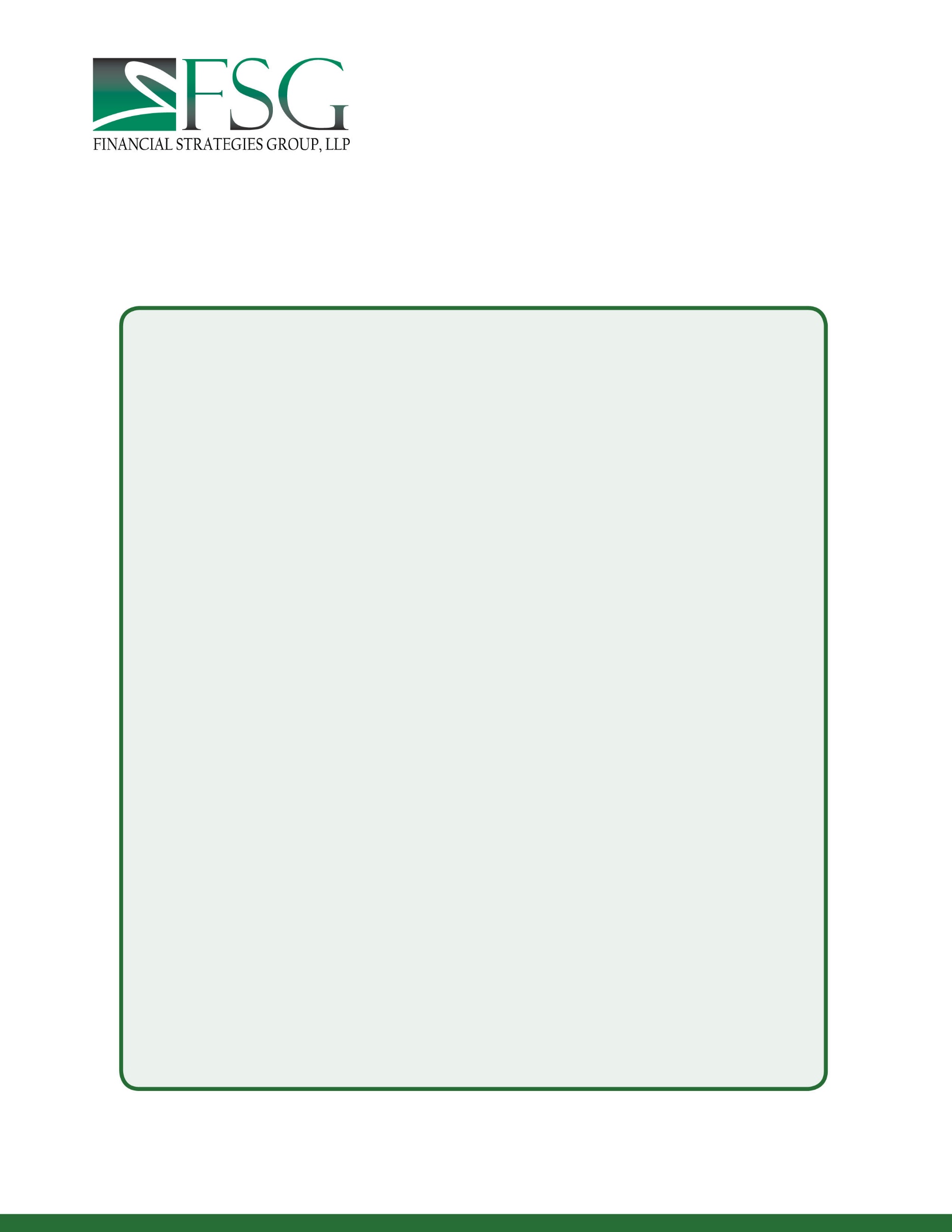
IF SO, REPLACEMENT? YES  NO  1035 EXCHANGE? YES  NO

COMPANY(IES):

POLICY NUMBER(S) AND DATE ISSUED:

DEATH BENEFIT(S):

CURRENT PREMIUMS:



**INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

**PLEASE PROVIDE A LIST OF ALL MEDICAL DOCTORS AND HOSPITALS YOU HAVE**

**BEEN TO IN THE PAST 5 YEARS (including date last seen, reason, name, address,**

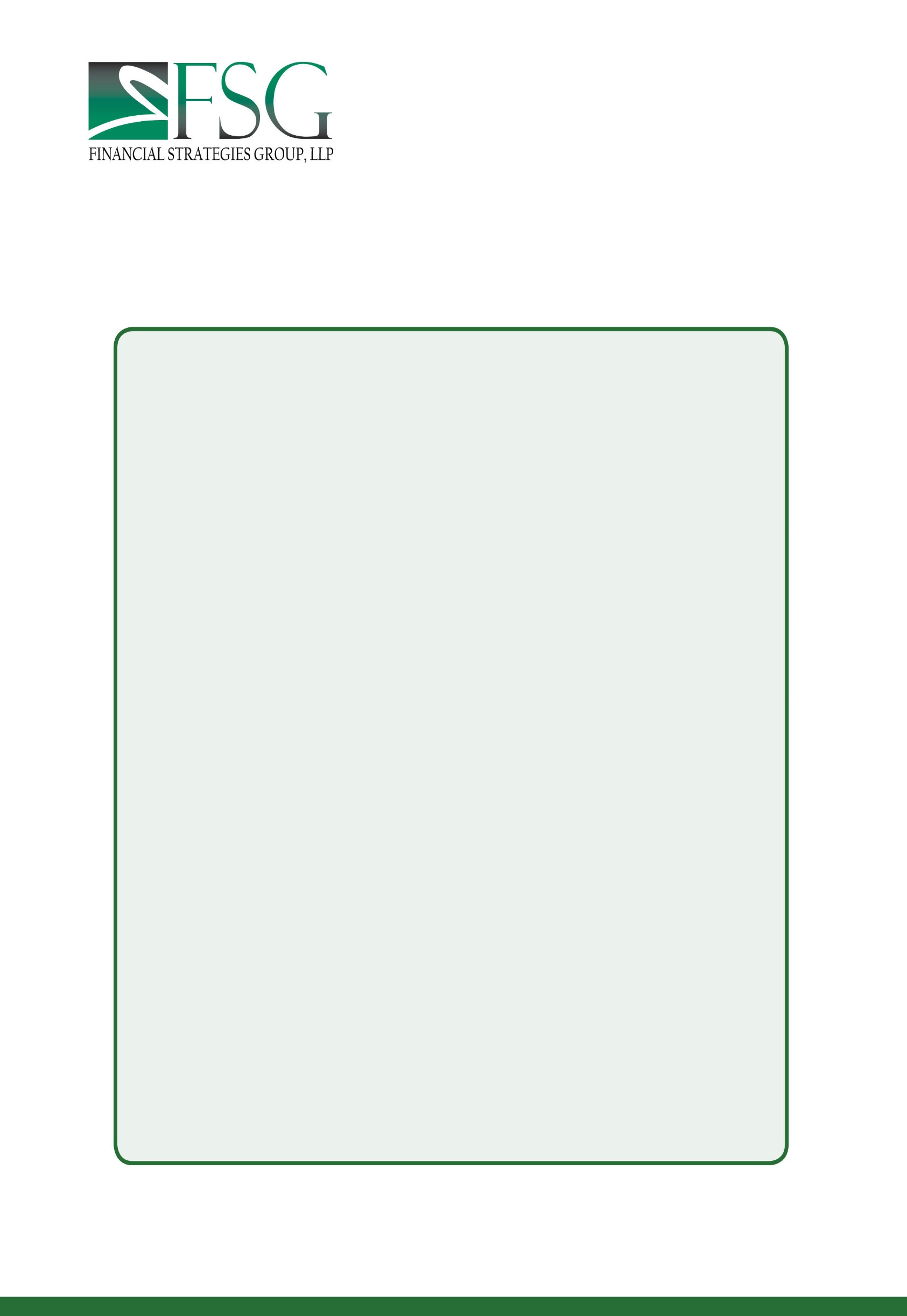
**phone number):**

* Name:
  + Address:
  + Phone number:
  + Date last seen, reason and outcome:
* Name:
  + Address:
  + Phone number:
  + Date last seen, reason and outcome:
* Name:
  + Address:
  + Phone number:
  + Date last seen, reason and outcome:

**\*PLEASE MAKE SURE TO LIST ALL DOCTORS SEEN. IF THERE ARE MISSING**

**DOCTORS, THIS CAN DELAY THE PROCESS BY 4-6 WEEKS AS THE**

**UNDERWRITER NEEDS YOUR COMPLETE MEDICAL FILE\***

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**SPOUSES INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

SPOUSE’S LEGAL NAME:

(FIRST, MIDDLE, LAST)

MALE  FEMALE  DRIVERS LICENSE #:

DATE OF BIRTH:       STATE:       EXP DATE:

HEIGHT:       WEIGHT:       BIRTH STATE:

PHONE NUMBER:       SSN:       EMAIL ADDRESS:

EMPLOYER:       JOB TITLE:

DUTIES:       WORK PHONE#:

WORK ADDRESS:

CITY:       STATE:       ZIP:

YEARS EMPLOYED AT CURRENT JOB:

PRIMARY DOCTOR NAME:       DATE OF LAST DOCTOR VISIT:

REASON FOR LAST VISIT:

INCOME: $      UNEARNED INCOME: $

BENEFICIARY NAME:

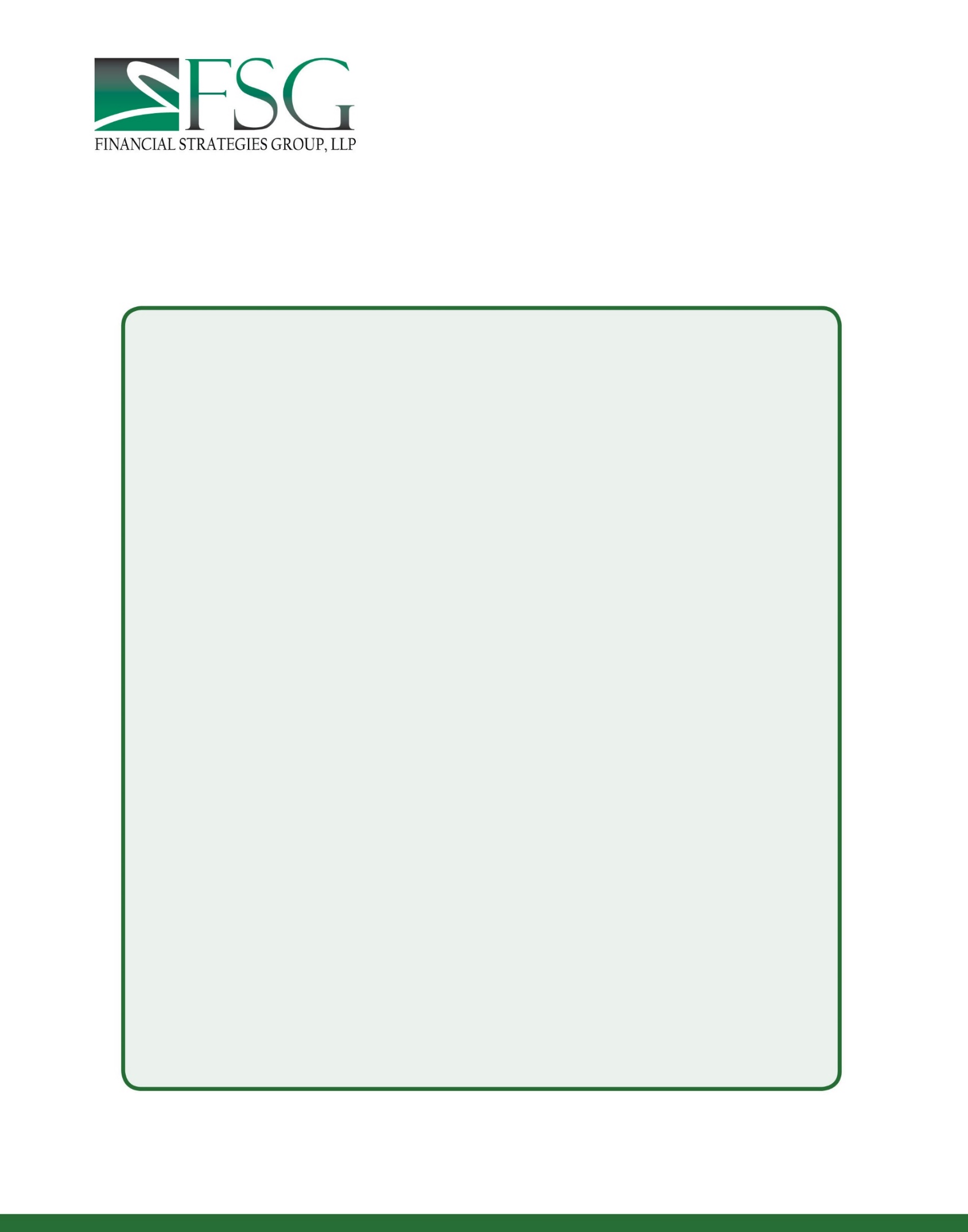
BENEFICIARY SSN:

BENEFICIARY DATE OF BIRTH:

**FAMILY HISTORY**

LIVING OR CAUSE OF DEATH AND AGE

MOTHER:       FATHER:

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**SPOUSES INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

ANY OTHER LIFE INSURANCE INFORCE? YES  NO

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COMPANY(IES):

POLICY NUMBER(S) AND DATE ISSUED:

DEATH BENEFIT(S):

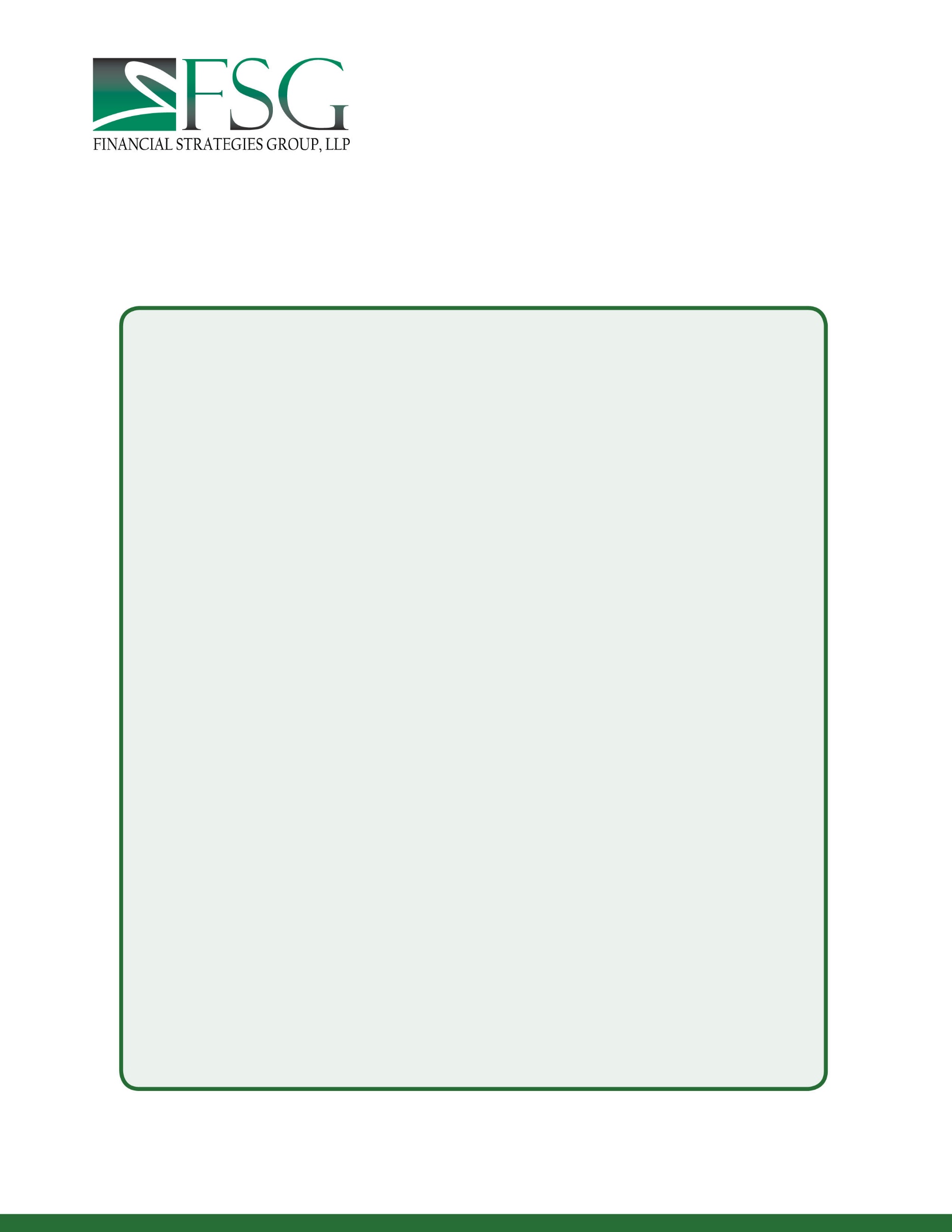
CURRENT PREMIUMS:

**SPOUSES INFORMATION FOR A**

**LIFE INSURANCE APPLICATION**

FSG Medical History Quick Quote

|  |  |  |  |  |
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| **Section A – Personal Information** | | | | |
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| 15 | Been in a motor vehicle accident, had a DUI or have more than two moving violations? | |  |  |
| 16 | If answered **YES** to any question 1-15 above please provide details: | | | |
| 17 | Name and address or phone number of your primary care physician and any specialist consulted: | | | |





Congratulations on your decision to apply for life insurance. This sheet will break down the steps in the process.

Step 1 – Client(s) completes a short medical questionnaire and signs a HIPPA agreement.

- Make sure to include all doctors seen

Step 2 – FSG sends Quick Quote to a hand selected group of top insurance carriers for tentative offers. (4-5 days)

Step 3 – FSG prepares an offer letter showing a comparison of competitive offers. (2 days)

Step 4 – Financial advisor contacts client to review offer letter and pick the most appropriate carrier.

Step 5 – Financial advisor and client sign a pre-completed application and send it back to FSG. (Premium may be submitted at this time for certain death benefit amounts.)

* FSG orders medical records and sends them to the carrier (3-4 weeks)
* If all medical records are not received by the end of 3 weeks, it may be advisable for the client to contact their doctor to help speed up the process.

Step 6 – Client receives phone call to schedule insurance exam and possible inspection report.

* This is a simple exam with the main goal of checking the client’s vital organs.
* The exam lasts approximately 20-30 minutes and is scheduled around client’s

calendar at their home or work.

* See below for how to prepare for the exam.

Step 7 – Any request for missing forms or information is sent to the agent/FA to reach out to the client. Forms can be faxed or emailed back, except for the 1035 form.



Step 8 – Assuming all required signatures have been received, it is underwritten medically and financially.

Step 9- Once approved, the carrier issues the policy.

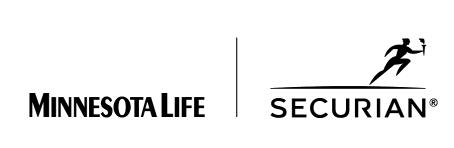
- In 1035 exchange cases, the exchange is initiated with the replaced carrier(s). Policy will be issued once the funds have been received. (min 2 weeks; can take longer)

Step 10 – Once the policy is received at FSG, it is reviewed, outstanding delivery requirements are flagged for signature, and then sent to the financial advisor. (1 week)

Step 11 – The financial advisor delivers the final policy and acquires any needed signatures, to include premium, if not already paid. Financial advisor returns the signed delivery requirements back to FSG.

**Insurance Exam Preparation Tips**

* You may be required to fast for 4-8 hours prior to the appointment
* Limit salt and high-cholesterol foods 24 hours prior to the appointment
* Avoid strenuous exercise 12 hours prior to the appointment
* Limit caffeine and nicotine 1 hour prior to the appointment
* Drink a glass of water 1 hour prior to the appointment
* Provide names and dosages of current medications
* Women, please mention to the examiner when making your appointment if you will be menstruating at the time so that a better time may be arranged





FSG Works Directly With: