

THE PRODUCERS FIRM

P. O. Box 879
Bristol, CT 06011

Tel: (860) 584-8461
Fax: (860) 584-8462
www.jegoss.com

“BETTER INFORMATION FOR BETTER QUOTES”

Agent’s Name _____
Agent’s Address & Telephone Number _____
Name of Proposed Insured _____
Date of Birth _____
State of Residence _____
Height _____ Weight _____
Smoker () Nonsmoker ()
Male () Female ()
Amount of Coverage _____
Product Type _____

Note: If proposed insured is applying for disability, please provide occupation, job description and income. If proposed insured is applying for term insurance, please state the level of term insurance (5, 10, 15, 20, 30).

CEREBRAL PALSY RELATED UNDERWRITING QUESTIONS

1. What are the means of locomotion? (i.e. wheelchair, walker, etc.)
2. Does he/she have aids who assist in the care of the proposed insured and assist in the needs of daily living?
3. Is there any kidney or bladder impairment?
4. What type of medication is he/she taking? How much and how often?
5. Does he/she work full time or part time? How long have they been employed? What is their occupation?
6. Proposed Insureds’ exercise habits?

FAMILY HISTORY

	<u>AGE IF LIVING</u>	<u>STATE OF HEALTH OR CAUSE OF DEATH</u>	<u>AGE AT DEATH</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers &	_____	_____	_____
Sisters	_____	_____	_____