

AGENT & CASE INFORMATION

AGENT NAME

PHONE

E-MAIL

PROPOSED INSURED

CLIENT NAME

DATE OF BIRTH

STATE

HEIGHT

WEIGHT

FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. When was the proposed insured first diagnosed with hyperglycemia?

2. What were the last four glycohemoglobin levels?

3. What were the last four glucose levels?

4. What were the last four microalbumin levels?

5. Is the condition controlled?

☐ Yes ☐ No

If no, provide details:

Please e-mail the completed form to Brad Kadelski · brad@brookfieldpartners.com

Brookfield Insurance Partners, LLC · Brookfield, MA · (p) 866-639-0443 · info@brookfieldpartners.com · www.brookfieldpartners.com

6. Are there any other health issues?

☐ Yes ☐ No

If yes, provide details. Additional questionnaires may be required.

7. Is the proposed insured currently taking any medication(s)?

☐ Yes ☐ No

If yes, provide name, dosage and frequency of medication(s)