

Contemporary Financial Marketing, Inc.

Impaired Risk Client Pre-Qualification Worksheet

Agent Information

Name	Phone
Company	Fax
Date	E-mail

Client Information

Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Soc. Sec. #	
Date of Birth/Age	Height	Weight	
Yearly Earned Income	Occupation		
Address	City	State	Zip
Tobacco Use <input type="checkbox"/> Never <input type="checkbox"/> Past Year <input type="checkbox"/> Past 2 Years <input type="checkbox"/> Past 3 Years <input type="checkbox"/> Past 5 Years			

What tobacco was used, how much and when last used

Plan Information

<input type="checkbox"/> Term <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Survivorship <input type="checkbox"/> LTC <input type="checkbox"/> Annuity <input type="checkbox"/> DI	
Death Benefit Desired	Premium Desired
Will premiums be financed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi <input type="checkbox"/> Qtr <input type="checkbox"/> Monthly
Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Purpose of Insurance

Family History

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer

Yes No

If yes, please provide the following details; relation, diagnosis, approximate age of disease onset, age at death (if deceased)

Basic Rx (Cholesterol, Blood Pressure, etc & Dosages)

What other meds do you currently take and why if not already explained in another section



Mail To 10224 Water Crest Drive Fishers, IN 46038 or Fax To 317 678 7204

Drug and Alcohol Usage

Check here if this section is not applicable

Do you currently drink alcohol Yes No

Date of last consumption

Note the amounts Beer

Wine

Liquor

Did you ever drink substantially more than present Yes No

Have you ever been arrested for driving under the influence of alcohol Yes No

If yes, provide date(s) & details

Have you ever used illegal drugs or sought treatment because of drug use Yes No

If yes, provide details

Types of Drug(s) used

Date of last use

Doctor / Facility Treatment / Date(s)

Coronary

Check here if this section is not applicable

Dates/details of treatment/surgery (examples Angioplasty, Bypass)

Number of diseased vessels

Date of last stress EKG

Result

Any pain since treatment/surgery Yes No

Cancer

Check here is this section is not applicable

Name and location of cancer

Stage and grade

Dates/details of treatment/surgery



Diabetes Check here if this section is not applicable

Date of diagnosis

Treatment Diet Only Oral Meds Insulin

Provide details on treatment

Do you regularly test your blood sugar glucose Yes No Results

Latest glycohemoglobin (A1C) test Date

Result

Have you even been diagnosed with having protein and/or microalbumin in your urine Yes No

Have you EVER had

 Eye Trouble Heart Trouble High Blood Pressure Kidney Trouble Neuritis/Neuralgia Insulin Reactions**Depression** Check here if this section is not applicable

List the date(s) and diagnoses

Number of episodes

Provide details on treatment and medication

Has the client been hospitalized for psychiatric treatment

History of

 Substance Abuse Personality/Psychotic Disorder Suicide Thoughts/Attempts**Hazardous Activities** Check here if this section is not applicablePrivate Pilot Yes No

Flight locations

If Private Pilot, provide details

Total number of hours flown
as a Pilot in CommandHow many hours flown per year & expected in the next 12
monthsIFR (instrument flight rating) Yes NoDoes the client participate in the following activities Scuba Diving Bungee Jumping Skydiving Mountain Climbing Hang Gliding Auto/Motorcycle Racing Other Hazardous Activity

If yes to any, please provide details below



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