



Affiliated Marketing Group
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IMPAIRED RISK QUESTIONNAIRE

Submit the specific questionnaire for each of your client's health impairments.
 Provide as much detail as possible in order to obtain the best offer.

Contact Person:

Date _____ Agent's Name: _____ STATE _____

Agent's E-mail (provide only if you want to receive communications via email):

Agent Phone #: _____ Agent Fax #: _____

How do you wish to be contacted with offer: Email Fax Phone

Applicant's Name: _____ DOB: ____ / ____ / ____

Face Amount \$ _____ TERM: 5 10 15 20 30 UL

Maximum Premium Acceptable \$ _____

Premium mode: Annual Semiannual Quarterly Monthly

MALE FEMALE Is client a US Citizen? _____

QUESTIONS FOR POTENTIAL CLIENTS

Height: ____ ' ____ " Weight: ____ lbs Cholesterol level _____ HDL _____

Does client use tobacco in any form? No Yes Type? _____

Has client ever used any form of Tobacco? No Yes Type? _____

Quantity per week? _____ Date when use was terminated? _____

Has client been rated? *If yes, list companies, dates, reasons, how rated and premium amount offered*

Has client been declined for life insurance? *If yes list companies, dates, reason*

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide? (Please show age at onset and date of death) use separate sheet if necessary

PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is policy to be Replaced?