Impaired Risk Assessment Form

Not an application for life insurance

Requested Plan of Insurance *MUST BE COMPLETED*

Face Amount Desired: _____ Type of Plan: _____
Purpose of Insurance: _____
Is this case being considered by another agency? _____
Other Inforce Insurance Information:

Carrier: *Death Benefit:* *Type:* *Premium:* *Replacing?:*

_____
_____
_____
_____

Personal History

Name:_____
Gender:_____ Date of Birth: _____ Social Security:_____
U.S. Citizen? Yes☐ No☐ Permanent Resident? Yes☐ No☐ If not, Visa Type: _____
Place of Birth: _____Occupation:_____
When last used tobacco/nicotine? Type?_____
Address: _____ City: _____ State: ____ Zip: _____
Cell/Home Phone:_____ Business Phone:_____Height: _____ Weight:_____

General Risk History

1. Have you ever received treatment for alcoholism/drugs? If yes, provide dates and details.
2. Have you filed for bankruptcy in the last 12 months or have a bankruptcy pending?
3. Hazardous Activities: Scuba Diving☐ Sky Diving☐ Private Pilot ☐

Medical History *MUST BE COMPLETED*

4. List your Primary Physician and the date, reason and outcome of your last consultation:_____
   _____
   _____
   _____

5. List any other physician/specialist you have seen, been referred to or treated by in the last 5 years:_
   _____
   _____
   _____

6. Please list any clinics, hospitals or medical facilities where you have been treated in the last 5 years:
   _____
   _____
   _____

7. Please list all current and past medications taken during the last 5 years including the dosage and reason prescribed. _____

_____

_____

_____

_____

Has any person to be covered been diagnosed with:

8. Epilepsy, fainting spells, nervous or neurological condition, neuritis, paralysis, or any disease or abnormality of the brain? Yes☐ No☐
9. Heart attack, murmur, palpitation, or high blood pressure, anemia, varicose veins or any disease or abnormality of the heart, blood, or blood vessels? Yes☐ No☐
10. Tuberculosis, asthma, pleurisy or any disease of the lungs, bronchial tubes, throat or respiratory system? Yes☐ No☐
11. Ulcer, indigestion, colitis, gall stones, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, or liver? Yes☐ No☐
12. Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital systems? Yes☐ No☐
13. Diabetes, gout, or any disease or abnormality of the thyroid or other glands? Yes☐ No☐
14. Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones? Yes☐ No☐
15. Any disease or abnormality of the eyes, ears or skin? Yes☐ No☐
16. Cancer or tumor? Yes☐ No☐
17. Any physical deformity or defect? Yes☐ No☐
18. An autoimmune disease such as lupus, multiple sclerosis, Sjogren's syndrome or others? Yes☐ No☐
19. ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection? Yes☐ No☐

Family History

	Age if Living	Age at Death	Current Health/ Cause of Death
Father			
Mother			
Sibling(s)			

Please provide details to any YES answers to questions #1-19, including but not limited to all dates, diagnoses, duration, outcome, treatment and medications prescribed:_____

_____

_____

_____

_____

_____

_____

Adverse Action or Table Rating Offered by Another Company?

Date: *Carrier:* *Death Benefit/Plan:* *Rating:* *Reason:*

_____

_____

_____

Agent Name: _____

Phone:_____

Email: _____

Return all pages to: impairedrisk@securelifefinancial.com

1-800-991-6510