Quick Quote Sheet

Advisor Information

Ashlin Hadden
Advisor

Ashlin Hadden Insurance
Company

Date

Ashlin@AshlinHaddenInsurance.com
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317-771-9185
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317-219-0809
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Client Information

Client Name ____________ Date of Birth ____________ Occupation ____________

Full Physical Address ____________

Plan and amount of insurance requested: ____________

Has the case been submitted to other companies in the last 12 months? ○ Yes ○ No

If yes, list companies, dates, and action taken: ____________

Medical History

Height: ____________ Weight: ____________ ○ Male ○ Female

Any weight change (10 pounds or more) in the last year? ____________ How much? ____________

Reason for change: ____________

Any nicotine use within 60 months? ○ Yes ○ No If yes, type and date of last use: ____________

Has client seen a doctor within past 3 years? ○ Yes ○ No If yes, when and why? ____________

____

What tests were done? ____________ Results: ____________

Latest blood pressure reading: ____________ Date: ____________

EKG Results: ____________ Date: ____________

Cholesterol/HDL Results: ____________ Date: ____________

List any medications, including over-the-counter medications and vitamins. Indicate dosage and the reason for taking the medication.

____

____

Does client have a routine exercise program? ○ Yes ○ No If yes, please describe: ____________

Driving History

In the past 5 years, has client been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had their driver's license suspended, restricted or revoked? ○ Yes ○ No

If yes, provide details: ____________

Quick Quote Sheet

Family History

Has any family member had cancer, diabetes, high blood pressure, heart disease or kidney disease prior to age 60? ○ Yes ○ No

If yes, identify family member, disorder and age at onset: ____________________

Cardiac Disorder

Name and address of cardiologist: ____________________

____

Date and reason for last visit: ____________________

Date of most recent stress test: __________ Results: ____________________

Date of most recent echocardiogram: __________ Results: ____________________

Any History of	Date of Onset:	Treatment Given and Results
Angina (chest pain)		
MI (heart attack)		
Irregular heart beat		
Valve Disorder		
Coronary artery disease		

Ever had the following	Date:	Results:	
Coronary catheterization?			
Bypass surgery (CABG)?			# of Vessels:
Angioplasty (PTCA)?			# of Vessels:
Valve surgery or replacement?			Which Valve?
Stent Placement			Which Arteries? Amount of blockage?

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Any current symptoms (chest pains, pressure, dizziness, blackouts, shortness of breath, etc.)? ____________________

If so, how often? ____________________

What medication is client taking (including over-the-counter, medication and aspirin? ____________________

____

____

Does client carry nitroglycerin? __________ Date of last usage? __________

*Copies of catheterization reports, stress tests, and echocardiograms will assist in evaluation the client's history

Asthma/COPD

When diagnosed: __________ Medication: __________ # of Attacks per year: __________

Date and severity of last attack: __________ Seasonal? __________

Any hospitalizations? __________ When? __________

Aviation

Hours flown as Pilot or Co-Pilot: __________ Purpose (civilian, military): __________

Any Other Avocation

Please specify: ____________________

Cancer

Type of Cancer: __________ Location: __________

Staging: __________ Grading, or copy of pathology report: __________

Any positive lymph nodes: __________ Depth or lever: __________

Date of surgery: __________ Any radiation or chemotherapy: __________ If yes, date treatment ended: __________

Any recurrence of cancer: __________ Any other medical problems: __________

Crohns/Colitis

When diagnosed: __________ Any surgery? __________ # of attacks per year: __________

Current medication: __________ Date of last episode: __________

Diabetes

Date diagnosed: __________ Treatment (oral meds, insulin, diet)? __________ # units of insulin: __________

# of regular doctor visits per year? ____________________

Any other medical impairments or complications: ____________________

Latest fasting blood sugar and date: __________ Latest glychemoglobin and date: __________

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High Blood Pressure

Date of diagnosis: ____________________ Your average readings: ________________ Do you monitor readings at home?__________

Medication: ____ Any other impairments? ____

Lab Abnormalities

What tests were abnormal? ____ Results and date: ____________________________________

Any diagnosis given? ______________________________________ How long has test been abnormal? ______________________________

Psychiatric

Diagnosis: ________________________ Date: ________________ Medication: ____________________ Hospitalization:__________

Suicide attempts? ______________________________________ Currently employed? ____

Substance Abuse

Date stopped using: _______________________ Duration used: ____________________ Kind of substance:___________________

Amount used: _____________________________ Type of treatment: ____

Attend AA or other programs? ____ Any relapses? ____________________________________

Are liver functions normal? _________________________________ If no, give readings: ____

Any motor vehicle violations or DUIs? ___________________________ Any other medical problems?_______________________________

TIA/CVA Seizures

(Transient ischemic attack-ministroke/stroke)

Date of episode: ____________________ # of episodes: ______________________ Any residuals? ______________________________

Type of treatment or medication:____

Any Impairment Not Listed Above

Diagnosis given and date: ____

Treatment: ____

Medications: ____

Date of last follow-up: ____

Additional Comments

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Please attach additional page if needed

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