CHESAPEAKE BROKERAGE
INTEGRITY • TRUST • EXPERIENCE
Life Insurance | Long-Term Care | Disability | Annuities

INFORMAL INQUIRY

Not an application for life insurance

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

PRODUCER INFORMATION

Producer:_____ Date:_____
Face Amount:_____ Product: _____

PROPOSED INSURED INFORMATION

Applicant Name:_____ ☐ Male ☐ Female DOB:_____
SS#:_____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ ☐ Home ☐ Work ☐ Mobile

Occupation: _____

AVOCATION/ACTIVITY RISK

Do you participate in any hazardous activities? ☐ Yes ☐ N
If yes, contact Chesapeake Brokerage underwriting department for the appropriate avocation form(s).
☐ Flying ☐ Scuba ☐ Mountain Climbing ☐ Auto Racing ☐ Hang Gliding ☐ Other
Details: _____

Do you have any plans for foreign travel? ☐ Yes ☐ No
Details: _____

Have you ever used any kind of tobacco product? ☐ Yes ☐ No
Type of Product: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Vape ☐ Chew
Frequency: ☐ Daily ☐ Weekly ☐ Monthly
If type includes cigars, how many cigars have you smoked in the past year? _____
Date Last Used: _____

Do you currently use marijuana? ☐ Yes ☐ No
Delivery Method: ☐ Smoke/Vape ☐ Edible ☐ Oil
Purpose: ☐ Recreational/Social ☐ Medicinal
If Medicinal, do you have a card? ☐ Yes ☐ No Reason: _____

Driving History
In the past 5 years have you had any moving violations and/or DUI's? ☐ Yes ☐ No
Details: _____

Do you drink alcohol? ☐ Yes ☐ No
If "Yes", provide frequency, type and amount. _____

Have you received medical treatment or counseling for drug or alcohol abuse or been advised by a licensed medical professional to limit or discontinue your use of alcohol or any prescription or non-prescription medication? ☐ Yes ☐ No
If "Yes", provide details: _____

FAMILY MEDICAL HISTORY

Family Member	Current Age	Age at death & cause	History of Heart Disease?	History of Diabetes?	History of Cancer?	Type
Mother			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Father			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Sibling 1			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Sibling 2			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

MEDICAL INFORMATION

Height: _____ Weight: _____

Do you have a history of any of the following?

High Blood Pressure ☐ Yes ☐ No Most recent reading: _____

High Cholesterol: ☐ Yes ☐ No Most recent reading: _____

Heart Condition/Coronary Artery Disease ☐ Yes ☐ No

☐ Heart Attack ☐ Bypass Surgery ☐ Stent(s)

Date of event: _____ Date of Last EKG/Stress Test: _____

Diabetes ☐ Yes ☐ No

At what age were you diagnosed? _____

Most recent A1c level:_____Current glucose reading: _____

Respiratory Disease ☐ Yes ☐ No

☐ COPD ☐ Asthma ☐ Sleep Apnea

If you have sleep apnea, are you CPAP compliant? ☐ Yes ☐ No

If you have asthma, date of last pulmonary function test: _____

Cancer ☐ Yes ☐ No

Type of cancer: _____

Was there a biopsy? ☐ Yes ☐ No Cancer stage if known: _____

Date of surgery/biopsy, if any? _____

Date of completion of radiation treatment: _____

Date of completion of chemotherapy: _____

Anxiety, depression, bipolar disorder or attention deficit disorder? ☐ Yes ☐ No

If "Yes", provide details: _____

_____

Alzheimer's disease/Dementia ☐ Yes ☐ No

If "Yes", provide details: _____

_____

Please list all medications being taken: _____

_____

Please list any medical conditions not indicated above: _____

_____

_____

PHYSICIAN INFORMATION

Physician Name: _____
Phone: _____
Address: _____
Date Last Seen: _____
Reason: _____

Physician Name: _____
Phone: _____
Address: _____
Date Last Seen: _____
Reason: _____

Physician Name: _____
Phone: _____
Address: _____
Date Last Seen: _____
Reason: _____

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Phone: _____
Address: _____
Date Last Seen: _____
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Address: _____
Date Last Seen: _____
Reason: _____

ADDITIONAL NOTES: _____