

RACCUGLIA FINANCIAL BROKERAGE, INC.

“Commitment to Integrity and Service”

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QUICK QUOTE INFORMATION

(Fax: 913-385-9055 or Email: quickquote@rfb-inc.com)

Agent / Agency Name: _____ Phone no. _____

Email Address: _____ State: _____

Client Name: _____ State of application: _____

Date of birth: _____ Sex: Male Female Height: _____ Weight: _____

Tobacco: Yes No Type: _____ Ins. Amount: _____

Other Company Actions: Date: _____ Standard: _____ Declined: _____ Rated: _____

Client's Illness: _____ When diagnosed: _____

Type of treatment: _____ Surgery: _____ Date: _____

Medication: _____

Other type of treatment: _____

Last doctor visit for this impairment or any other impairment: _____

Last Cholesterol reading: _____ Ratio: _____ Date: _____ BP controlled: Y N

Number of Days per week of exercise: None 1—3 4—6 7 or more

Type of Exercise: _____

Family History: Either parent or Sibling died before Age 60, other than accident? Y N

If Yes: _____ Relationship _____ Cause _____

Diabetes: Type I Type II When diagnosed: _____

How is it controlled: Diet Diet & Oral med. Diet & Insulin

Most recent Sugar reading: _____ Most recent A1c reading: _____ Date: _____

Last doctor visit: <6mos. 6—12mos. 12—24mos. >24mos.

Impairments: EKG abnormalities Eye Trouble Protein in urine Amputations

Neuropathy of loss of feelings Skin ulcerations Heart Trouble

Heart Disease: Heart Attack: Y N Mild Moderate Major

Date or Age of Heart Attack: _____

Bypass Surgery: Y N How many Vessels: _____

AngioPlasty: Y N How many Stents were Placed: _____

Ejection Fraction (EJ) from most recent Stress Test: _____ % Date: _____

Select all conditions which Preceded the Procedure: Heart Attack Chest Pain

Irregular Stress EKG Extreme Fatigue

Cancer: When was the Diagnosis: _____
_____*Colon or Rectal (Need Duke's Scale: A1, B1, B2, C1, C2, D)* _____*Hodgkin's disease*
_____*Melanoma (Need Clark's Level: I, II, III, IV, V)*
_____*Prostate (Need Gleason Score: II, III, IV, V, VI, VII, VIII, IX, X)*
PSA reading prior to treatment: _____ Current PSA reading: _____
Stage of Tumor or Malignancy: 1, 2, 2A, 2B, 3, 3A, 3B, 4, 5, other: _____
Treatments received: _____Surgery _____Chemotherapy _____Radiation, _____Hormonal
Date of last treatment: _____ Any Reoccurrence of cancer: _____Y _____N

Stroke: Date of first Stroke: _____ Cause: _____
How many Strokes in past 24mos.? _____None _____One _____Two or more
Carotid Artery Surgery as a result of surgery: _____Y _____N If yes, Date: _____
Any Residual Neurological deficits: _____None _____Slurred Speech _____Loss of use of Limb
_____Restricted use of Limb _____Other _____

Drug Usage:

_____*Heroin, Morphine, Demerol, Methadone, etc.*
_____*Marijuana*
_____*Amphetamines (Benzedrine, Dexedrine, Methedrine, Preludin, etc)*
_____*Cocaine*
_____*Hallucinogens (LSD, DMT, Mescaline, Peyote, Psilocybin, PCP)*
_____*Sedatives/Tranquilizers (Librium, Valium, Quaalude, Dalmane, Placidyl)*
Were any prescribed by Physcian? _____Y _____N If yes, Which? _____
If using Marijuana: _____Quantity _____How often _____Dates of Usage:
From: _____ To: _____
Has Client sought treatment for Drug Use? _____Y _____N If Yes, Date(s): _____
_____*Doctors / Institutions consulted:* _____

Alcohol Usage: (Use only if history of Alcohol Abuse)

Does Client currently Consume Alcoholic beverages: _____Y _____N
If yes, Type & Quantity currently consumed: _____
Is the Client active in AA or other recovery groups? _____Y _____N If yes, how long: _____
Has client ever consulted a Doctor or Received Treatment for Alcohol use? _____Y _____N
If Yes, Details: _____
DUI: _____Y _____N If yes, When: _____

Depression:

Diagnosed as: *Depressed (Situational due to Job, Death in family, Illness, etc.)*

Manic—Depressive (Bipolar) *Anxiety* *PTSD* **If yes, Date of Diagnosis:**

Suicide ever attempted? *Y* *N* **If yes, Date:** _____

Ever Hospitalized: *Y* *N* **If Yes, Date & how long:** _____

Lost Work in past 12mos. Due to depression: *Y* *N* **Is client currently seeing a mental health therapist?** *Y* *N* **If Yes, Frequency:** _____

When was the last visit to the Therapist? _____

Driving Violations: (Use only if 3 or more moving violations in past 5yrs. or if DUI's in records)

When was the last Speeding violation: _____

How many moving violations in the past 5yrs.? _____ **Dates:** _____

Does client currently hold a valid driver's license? *Y* *N* **State & Exp.** _____

Has Client ever been convicted of driving under the Influence of Alcohol or drugs? *Y* *N*

If yes, Date(s): _____

Military information:

Active Duty: *Y* *N* **If yes, Branch of Service:** _____ **Orders to be deployed overseas?** *Y* *N* **If yes, to what country:** _____

Rank: _____ **Military Occupation:** _____

National Guard: *Y* *N* **Rank:** _____ **Occupation:** _____

Orders for Deployment: *Y* *N* **If Yes, Location:** _____

Miscellaneous Information: *Married* *Single* *Divorced*

Occupation: _____

All Medications currently being taken: _____

