

Your First Step in establishing a program that will provide excellent coverage is to complete the following questionnaire. Your information will be Processed against over 100 different companies and a proposal will be created. Providing as much information as possible will give you the best chance to get excellent rates.

Looking for Life Insurance **Bridenstine and Associates** Fax 612-395-5233

Contact First Name _____ Contact Phone Number _____
 Contact Last Name _____ Fax _____
 Address 1 _____ Email _____
 Address 2 _____ Evening Phone _____
 City _____ State _____ Zip Code _____ Cell Phone _____

Contact Notes _____

Insured Name _____
 Insured Social Security Number _____ Coverage Amount? _____
 Occupation _____ Desired term period? _____
 Insured Date of birth _____ Do you want an umbrella Quote? _____
 Insured Gender _____
 Insured Height _____
 Insured Weight _____

Are you a citizen of the United States? Yes No
 Have you lived outside the United States during the last 3 years? Yes No
 Do you plan to leave the United States for travel or residence during the next 3 years? Yes No
 Please list the foreign countries that you are planning to visit reside? _____
 Do you currently work in a hazardous occupation? Yes No
 Do you participate in any risky outdoor activities? Yes No
 Do you fly as a pilot, co-pilot or crew member of an aircraft? Yes No
 Are you an active member of the military or military reserve? Yes No
 Have you received three or more moving violations or had your driver's license suspended/revoked in the past 5 years? Yes No
 Have you been found guilty of reckless driving or driving under the influence (DUI/DWI)? Yes No
 When was the last time that you used any type of tobacco product or nicotine substitute? _____
 Is there any family history of cardiovascular disease before the age of 60? Yes No

Have you had any health symptoms or been treated for any of the conditions listed below?

AIDS and AIDS related	Yes <input type="checkbox"/> No <input type="checkbox"/>	Infertility	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcoholism	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint replacement	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatoid arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alzheimer's	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney stones	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizure disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Leukemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spinal disc disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Breast cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>	Substance abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>
COPD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lymphoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	TIA	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Manic depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcerative colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Melanoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Uterine disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Multiple sclerosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fatigue disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscular dystrophy	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Specify cancer details here	
Heart Disease or Bypass	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease or Bypass	Yes <input type="checkbox"/> No <input type="checkbox"/>		
High blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any demyelinating disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>		
HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Peripheral vascular disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		