new west insurance

A Principal Office of Insurance Designers

INFORMAL APPLICATION

New West Insurance is committed to comprehensive insurance analysis for clients. Our on-site underwriting program and information application process eliminates excess applications, examinations and excessive MIB reports. Learn how you are rated tentatively so you can start with the best potential formal application first!

Instructions

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages. If additional space is needed, use page 5 or add a separate page. Complete, accurate information produces the most competitive carrier offers. Because of the significant expense involved in purchasing medical records, New West's underwriting staff has final discretion regarding pre-purchase of client's medical records.

If submitting for informal Survivorship quotes, please complete a separate application for each proposed insured and submit together.

1. Proposed Insured Information

Last Name First Name MI

(Check one) _____ Male _____Female Daytime Phone ______________________________

Social Security Number ____ Date of Birth ______________________________

Drivers License # ____ State of issue ______________________________

Residence Address:

Address (Street)__________________________________(City)_____________________________(State)_______(Zip)___________

Employer ____ Position ____

Duties____ Year(s) in this occupation________

2. Foreign Travel/Citizenship

U.S. citizen? ______ How Long? ___________If no, country of citizenship ______________________ Dual Citizenship?___________

Have you traveled outside North America or Western Europe in the last 2 years or intend to do so in the next 2 years?______________

If yes, list dates traveled (or anticipated traveling dates), duration, country and purpose of trip on page 5.

3. Existing and Pending Insurance

A) Year issued Company Amount Purpose Keep or Replace?

____

____

____

____

B) Have you ever been rated substandard, declined or postponed when applying for Life, LTC or DI insurance?

Please include date and explain: ____

____

____

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4. Lifestyle and Avocation Information

A) Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years? __________ If yes, hours flown last year ____________ Anticipated hours next 12 months _________________

License type _________________Date of last flight__________ Aircraft type & purpose______________________________________

B) Have you engaged in or plan to engage in scuba or skin diving? ____

If yes, Number of dives last year________ Anticipated dives next 12 months___________ Maximum depth___________________

Where do you dive? (i.e. rivers, open ocean, etc)____

Purpose of diving (i.e. vacation, commercial, instructor)____

C) Have you engaged or plan to engage in any type of motor vehicle or boat racing? ____

If yes, please provide complete details on license type, circuit, frequency:

____

____

____

D) Have you engaged in or do you plan to engage in any mountain climbing, sky diving or any other hazardous sports or activities?

If yes, please provide details immediately below or on page 5 if more space is needed:

____

____

____

E) Have you had any moving violations or been cited for driving while impaired? ____

Please provide details and date of occurrences: ____

____

____

____

F) Have you declared bankruptcy, or been convicted of a felony offense in the last 10 years? __________________________________

Please provide details: ____

____

____

G) Do you use any tobacco or nicotine products presently? ____

How many years? ______

Type & Amount per day _____________ Any plans to quit? ____________________________________

H) Have you ever used tobacco in any form? (check one) cigarettes_____ cigar_______ chew ______ pipe_____ snuff_____

Date last used Type & Amount per day: ____

____

J) Do you consume drugs other than prescribed by a physician? ____

Please provide details: ____

____

____

K) Do you consume alcohol? _________ If yes, please specify type, quantity and frequency: ______________________________

____

____

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L) Have you ever been treated for, or recommended to seek treatment for alcohol or drug abuse? ______________________________

Please provide details: ____

____

____

M) Do you exercise regularly? ________________________

If yes, please specify type, duration and frequency per week:

____

____

____

N) Do you manage your diet? ________________________

Please explain: ____

____

____

____

5. Medical Information

A) HeightÁ´´´´´______´ÁÁ Weight _________ Any change greater than 10 pounds in the last 2 years? _______________________

If yes, please explain: ____

____

____

B) Medications - please list prescription and non– prescription medications used below be sure to include:

Date started	Medication & Dosage	Purpose	Prescribing Doctor's name	Results of use

6. Medical Care Providers Information

Please provide complete information for all doctors and health care facilities that have consulted with, or treated you in the last 5 years. If additional space is needed, please continue on page 5 or add a separate page.

Primary Care Physician's
Name____ Phone # _______________________________
Address (Street)______________________________________(City)___________________________(State)_______(Zip)____________
Date and purpose & results of last visit: ____

____

____

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Specialist or other Care Provider ____ Phone # ____________________________
Address (Street)____(City)________________________(State)_____(Zip)___________
Date and purpose & results of last visit: ____
____
____
____

Specialist or other Care Provider ____ Phone #____________________________
Address (Street)____(City)________________________(State)_____(Zip)___________
Date and purpose & results of last visit: ____
____
____
____

7. Medical Questions

Please provide details (diagnosis, onset date, duration of condition, treatments and current status) to any "Yes" answers on the next page Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have;

_______ A) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke (TIA), irregular heartbeat or any other disease or disorder of the heart or arteries?
_______ B) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?
_______ C) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
_______ D) Arthritis, gout or any bone, joint, muscle or skin disorder?
_______ E) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
_______ F) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
_______ G) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
_______ H) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
_______ I) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
_______ J) Cancer or tumors of any kind, malignant or benign?
_______ K) Any other health impairment or medically treated condition not yet mentioned?
_______ L) Been advised to seek treatment for any impairment or condition that has not been treated?

8. Family History

Have any immediate family members (parents, brother, sister) died prior to the age of 60? ________ Yes* _________ No

*If "yes", please identify family member(s), cause of death, and age at death:

____
____
____
____

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General and Medical Question Responses/Details

Please provide the question number and details as appropriate. For Medical questions, Please provide as much detail as possible regarding diagnosis, onset date, duration of condition, treatments, current status and caregiver/provider with contact information (if different from those listed in section 8.)

Question # Dates Details

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