Robert A. Brandon, Inc.

Preliminary Inquiry

Not an application for life insurance

Form **A**

PERSONAL HISTORY

Name: _____ ☐ Male ☐ Female SS # _____ U.S. Visa ☐ Yes ☐ No - U.S. Citizen: ☐ Yes ☐ No

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Place of Birth: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Kilos _____ lbs Annual Earned Income: $ _____

Occupation: _____ Net Worth $ _____

When last used tobacco? Cigarettes: _____ Cigars: _____ Other: _____ Have you ever received treatment for alcoholism/ drug treatment: ☐ Yes ☐ No

Hazardous Activities: Private Pilot: ☐ Yes ☐ No Scuba Diving: ☐ Yes ☐ No Sky Diving: ☐ Yes ☐ No

MEDICAL HISTORY – THIS SECTION MUST BE FULLY COMPLETED

1. Who is your Primary Physician and what is the reason date of last consultation:

Name: Address and phone number: Date: Reason for consultation:

2. Name of any other physician/ specialist you have seen, been referred to or treated by in the last 5 years? (Do no t include insurance examinations)

Name: Address and phone number: Date: Reason for consultation:

3. In what clinics, hospitals, or medical facilities have you ever been treated in the last 5 years?

Date: Duration of Stay: Reason and treatment given: Name, address and phone number of physician and hospital:

4. Please list all current medications, dosage and purpose for prescription?

Has any person to be covered had or been told he or she had:		Yes	No
A	Epilepsy, fainting spells, nervous or mental condition, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?	☐	☐
B	Heart attack, murmur, palpitation, or high blood pressure, anemia, varicose veins, or any disease or abnormality of the heart, blood, or blood vessels?	☐	☐
C	Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?	☐	☐
D	Ulcer, indigestion, colitis, gall stones, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, or liver?	☐	☐
E	Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital systems?	☐	☐
F	Diabetes, gout, or any disease or abnormality of the thyroid or other glands?	☐	☐
G	Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?	☐	☐
H	Any disease or abnormality of the eyes, ears, or skin?	☐	☐
I	Cancer or tumor?	☐	☐
J	Any physical deformity or defect?	☐	☐
K	An immune deficiency disorder, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection?	☐	☐

Please provide details of all YES answers to questions A – K, including but not limited to all dates, diagnoses, duration, outcome, treatment and medications prescribed:

FAMILY HISTORY

	Age if Living	Age if Death	Cause of Death
a) Father			
b) Mother			
c) Siblings			

Have any of your parents or siblings:

a) Had cardiovascular disease prior to age 60? ..... ☐ Yes ☐ No

b) Ever had diabetes, kidney disease, or other familiar disorder? ..... ☐ Yes ☐ No

TRAVEL

1. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? ☐ Yes ☐ No

2. Have you traveled in the last 5 years for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? ☐ Yes ☐ No

If YES to #1 or #2 PLEASE LIST DEATAILS OF TRAVEL:

Date: City/ Country: Duration of Stay:

WHAT ADVERSE ACTION OR TABLE RATING WAS OFFERED BY ANOTHER COMPANY?

Did your primary company work this case? ☐ Yes ☐ No

Carrier: Date: Death Benefit: Rating: Reason:

*** REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED ***

Face amount desired $ _____ ☐ Annually ☐ Monthly Type of Plan: _____

What will be the purpose of the insurance? _____

Is this case being considered by another Impaired Risk Agency? ☐ Yes ☐ No

OTHER INFORCE INSURACE INFORMATION: *(Continue in Form C)*

Carrier:	Policy No.	Death Benefit:	Plan Type:	Current Premium	Are you replacing this policy?
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No
				$	☐ Yes ☐ No

AGENT INFORMATION

Name: _____ Firm Name _____ SS# _____ ☎ _____

Address: _____ City _____ State _____ Zip _____

Email: _____

HAVE ATTACHED AUTHORIZATIONS SIGNED SO THAT MEDICAL RECORDS CAN BE OBTAINED

Send your completed documents to:

Robert A. Brandon Inc.
217 Aragon Avenue
Coral Gables, FL 33134
(305) 442-2340 Phone
(305) 441-2237 Fax
To send via email please call