RISK ASSESSMENT

ELITE AGENCIES
3110 W. Languid Lane, Phoenix, AZ 85086
Phone: (623) 322-0840 Fax Line: (623) 322-0282

Preliminary Inquiries --- Not an application for life insurance.

This riskfinder form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carriers.

Personal History --- (this section must be completed)

Name_____ Male/Female, Soc.Sec. # _____
Address_____City_____ State_____ Zip_____
Date of Birth_____ Age_____ Height_____ Weight_____ Monthly Income _____
Occupation_____

Tobacco/Nicotine Usage:

1. Have you ever smoked cigarettes: Yes / No If yes, date of last usage: _____
2. Have you ever used other tobacco or nicotine containing products: Yes ☐ / No ☐ (examples: cigar, pipe, snuff, nicotine gum or patch)

If yes, provide types and last date of usage: _____
_____

Agent Information – (this section must be completed)

Name_____ _____Soc.Sec. # _____
Address_____City_____ State_____ Zip_____
Phone Number_____ Fax_____
Email address_____

Requested Plan of Insurance – (this section must be completed)

Universal Life Variable Life Whole Life Term, Level Period _____
Survivorship* Disability Income, Monthly Benefit Amount _____
Face amount desired: _____
Premium Amount desired: _____ Annually/Monthly _____
What will be the purpose of the insurance _____
*Please have other proposed insured submit RiskFinder as well.

Provide details on pending and in-force coverage:

Company	Policy/Application Date	Amount	Class/Rating issued	Current Premium	Do you intend to replace?
					Y / N
					Y / N
					Y / N
					Y / N

Proposed Insured: _____ Soc.Sec.# _____

Medical History – (this section must be completed)

Who is your primary Care Physician? When did you last see him/her?	Dr.'s name, address and phone number	Date of visit	Illness
What other physicians have you consulted during the past five years? (Do not include insurance examinations)			

In what other hospitals, clinics, or other health facilities have you been treated?	Date of Visit	Illness
Please list all current medications		

Family History -- ☐ Check here if this section is not applicable

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Yes ☐ / No ☐
If yes, please provide the following details:

Relation (mother, father, brother, sister)	**Diagnosis**	**Approximate age of disease onset**	**(If decreased) Age at death**

Drug and Alcohol Usage Questionnaire - ☐ Check here if this section is not applicable

Do you currently drink alcohol? Yes ☐ / No ☐
Date of last consumption: _____
Note amount below:

Did you ever drink substantially more than present?
Yes ☐ / No ☐ If yes, when? _____
Note amount below:

Type	**Amount per week:**	**Type**	**Amount per week:**
Beer		Beer	
Wine		Wine	
Liquor		Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use? Yes ☐ / No ☐
Have you ever been arrested for driving under the influence of alcohol? Yes ☐ / No ☐
If yes, provide date(s): _____
_____

Have you ever sought medical treatment because of drug use or has drug use ever been a problem? Yes ☐ / No ☐
If yes, provide details: _____

Types of Drug(s) used: _____

Date of last use: _____

Proposed Insured: _____ Soc.Sec.# _____

Coronary -- ☐ Check here if this section is not applicable

1. Date of diagnosis of first chest pain: _____"_____"_____
2. Number of diseased vessels: _____
3. Dates/detailed of treatment/surgery (examples: angioplasty, bypass)

_____
_____
_____

4. Date of last EKG: _____"_____"_____

Results: _____

By whom?_____

5. Any pain since treatment/surgery? _____

Cancer -- ☐ Check here if this section is not applicable

1. Exact name and location of cancer: _____
_____
2. Stage and grade _____
3. Who would have the pathology report? _____
4. Dates/details of treatment/surgery: _____
_____

Diabetes -- ☐ Check here if this section is not applicable

1. Date of diagnosis: _____"_____"_____
2. Treatment: (circle one) Diet only Oral Medications Insulin

Details: _____

3. Do you regularly test your blood glucose: Yes ☐ / No ☐

Results: _____ Frequency: _____

4. Latest result of glycohemoglobin (A1C) test: _____ mg%

Date: _____"_____"_____

5. Have you ever been diagnosed with having protein and or microalbumin in your urine? Yes ☐ / No ☐
6. Have you ever had:
   a) Any eye trouble Yes ☐ / No ☐
   b) Heart Trouble Yes ☐ / No ☐
   c) High blood pressure Yes ☐ / No ☐
   d) Kidney trouble Yes ☐ / No ☐
   e) Neuritis/neuralgia Yes ☐ / No ☐
   f) insulin reactions Yes ☐ / No ☐

Hazardous Activities -- ☐ Check here if this section is not applicable

1. Are you a private pilot? Yes ☐ / No ☐ If yes, provide details below.
2. How many total house have you flown as pilot in Command? _____
3. How many hours do you fly per year? _____
4. Do you have an IFR (instrument flying rating)? Yes ☐ / No ☐

5. Do you participate in the following activities?
   a) Scuba Diving ☐
   b) Mountain Climbing ☐
   c) Buogee Jumping ☐
   d) Hang Gliding ☐
   e) Ultra Flying ☐
   f) Auto/Motorcycle Racing ☐
   g) Sky Diving ☐