

THE PRODUCERS FIRM

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“BETTER INFORMATION FOR BETTER QUOTES”

Agent’s Name \_\_\_\_\_  
Agent’s Address & Telephone Number \_\_\_\_\_  
Name of Proposed Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
State of Residence \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Smoker ( )      Nonsmoker ( )  
Male ( )          Female ( )  
Amount of Coverage \_\_\_\_\_  
Product Type \_\_\_\_\_

Note: If proposed insured is applying for disability, please provide occupation, job description and income. If proposed insured is applying for term insurance, please state the level of term insurance (5, 10, 15, 20, 30).

CEREBRAL PALSY RELATED UNDERWRITING QUESTIONS

- 1. What are the means of locomotion? (i.e. wheelchair, walker, etc.)
- 2. Does he/she have aids who assist in the care of the proposed insured and assist in the needs of daily living?
- 3. Is there any kidney or bladder impairment?
- 4. What type of medication is he/she taking? How much and how often?
- 5. Does he/she work full time or part time? How long have they been employed? What is their occupation?
- 6. Proposed Insureds’ exercise habits?

FAMILY HISTORY

	<u>AGE IF LIVING</u>	<u>STATE OF HEALTH OR CAUSE OF DEATH</u>	<u>AGE AT DEATH</u>
Father			
Mother			
Brothers &			
Sisters			