



Individual Life Proposal Request

Email or Fax Completed Form

info@michellecrawfordbenefits.com

Fax: 706-568-9979

Client Information:

Client Name: _____ Date of Birth: _____

Male Female

Height: _____ Weight: _____ lbs.

Nicotine Use

Nicotine Use Yes No Quit When _____

Form: Cigarettes Cigars Chewing Tobacco Other _____

Rate Class Desired Best Rate Preferred Standard Rated _____

Occupation & Duties: _____ Annual Income: _____

Plan of Insurance:

Term Years ROP Term Years Universal Life Indexed Universal Life Whole Life

Amount of Insurance: _____

Riders: Waiver of Premium Child Rider Accidental Death Benefits: _____

Long Term Care Critical Illness

Number of Years:(If Term) _____ Desired Monthly Budget: _____

Medical History:

Has the Client Been Treated for Any of The Following?

Alcohol/Drugs Cancer Diabetes Hypertension Depression

Lung Disorders Sleep Apnea Other _____

General Health Details:

Treatments (Within the Last 5 Years)

Medication(s) (Name & Dosage)

Family History: (Parents & Siblings) Deceased of Heart Disease Prior To Age 60

Yes No If Yes, Details: _____

Driving History: In the Past 10 Years, Has the Client Had Any Of The Following Motor Vehicle Related Incidents?

Moving Violation Reckless Driving DUI License Suspended or Revoked

If Yes, Details: _____

Visit our Website at www.michellecrawfordbenefits.com for additional sales tools.

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