Phone Number: (516) 364-7171
Fax Number: (516) 364-3030
6800 Jericho Tpke.
Suite 200AW
Syosset, NY 11791
www.cpgllc.com

Life Insurance Proposal Request

Agent: _____ Phone: _____ Fax: _____ E-Mail_____

Proposed Insured Name: _____ M ☐F Birth Date: _____
Second Insured:_____ M F Birth Date:_____
Face Amount: _____ UL(age guar__) WL Term: 10,15, 20 or 30 Survivorship 1035:$_____
Rate Class:_____ **STATE**:_____
Do you currently smoke cigarettes? Y☐N ☐ If no, did you ever smoke:Never ☐Quit ☐Quit(Date): _____
Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N
If Yes, please provide details:
_____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last:
_____

Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____
Has the Proposed Insured experienced a change in weight greater than 10 pounds in the past 12 months? Yes No
If YES, please specify: Pounds Lost/Pounds Gained Reason

Has the Proposed Insured EVER been diagnosed by, or received treatment from, a licensed member of the medical profession for any of the following? If YES, please circle ALL that apply and provide details below.

High Blood Pressure	Sleep Apnea	Cirrhosis
Heart Attack	Seizures	Hepatitis
Chest Pain	Stroke	Arthritis
Heart Murmur	Paralysis	
Diabetes	Multiple Sclerosis	
High Cholesterol	Parkinson's Disease	
Cancer (Type & Stage)	Alzheimer's Disease	
Asthma / Bronchitis	Memory Loss	
Emphysema	Colitis	

Details including dates of treatments, type and medications:

Family History: Parent or Sibling with Cancer or Cardiovascular Disease. If "Yes" provide onset, age and cause of death.

Driving History: Any moving violations or DUI in the past 5 years. If "Yes" provide details.

Current Medications: If "Yes" provide details.

Physician and Hospital Details

_____

Proposed Insured

	Name and Address	Reason	Date
What physician did you last consult? (other than insurance exams)			
What physicians have you consulted during the past 10 years?			
What hospitals or clinics have you been treated in during the past 10 years?			
Who is your personal physician? When did you last consult him/her?			

When applying for insurance have you ever been:	Name of Company	Reason	Year
Rated?			
Declined?			

Proposed Insured

Other than as indicated previously, within the past five years, has the Proposed Insured been diagnosed by any physician, practitioner or health facility as having had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility?

Is the Proposed Insured currently receiving any treatment by a licensed member of the medical profession or taking any prescription or nonprescription medications or supplements?

Does the Proposed Insured have any surgery, medical tests, treatment, or visits with a health professional scheduled in the next six months?

Has the Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection?

Has the Proposed Insured ever used cocaine, heroin, barbiturates, amphetamines, hallucinogens, or controlled substances except as prescribed by a health professional?

Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a licensed member of the medical profession or support group?

Has the Proposed Insured ever been arrested for driving under the influence (DUI) or for driving while intoxicated?

To the best of your knowledge and belief, has a parent or sibling ever had: heart disease, coronary artery disease, vascular disease, stroke/cerebrovascular disease, diabetes, cancer, or kidney disease? If YES, please provide details below.

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			

Please Return to:

(CONFIDENTIAL)