Graber & Associates — Life Quote Request

Agent Name: _____ **Date Needed:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Primary Insured: _____

Date of birth: _____

Sex: M☐ F☐

Tobacco use?: Y☐ N☐ **If yes, type:** _____

If no, how recently quit: _____

Height: _____ **Weight:** _____

Secondary Insured: _____

Date of birth: _____

Sex: M☐ F☐

Tobacco use?: Y☐ N☐ **If yes, type:** _____

If no, how recently quit: _____

Height: _____ **Weight:** _____

List details of any medical conditions

High blood pressure, Heart attack, MS, Stroke, Diabetes (A1C needed), High cholesterol, Cancer, Surgeries, Sleep apnea, Depression, Anxiety

Diagnosis date, treatment, medications, current status, lab levels...

Prescription Meds	Dose & Freq.	Taken For?

List details of any medical conditions

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Prescription Meds	Dose & Freq.	Taken For?

Death Benefit(s)	Product Type	If Term	Premium Mode	State App Signed In	Additional Riders
$					**Check All Desired:**
$	Term UL Cash Value Product Final Expense Carrier Preference: _____ _____	10 yr. 15 yr. 20 yr. 25 yr. 30 yr. 35 yr. 40 yr. *Will vary by company	Monthly Quarterly Semi-Annual Annual Lump-Sum Paid-Up Age: _____ 1035 Exchange Amount: _____		☐ Child Rider Face Amount: ☐10k ☐15k ☐25k ☐ Waiver of Premium ☐ Accidental Death Benefit ☐ Return of Premium ☐ Guaranteed Insurability
$					
$					
$					
$					

Email completed forms to: tchurch@graberassoc.com **or** chanson@graberassoc.com

*Agent use only