

**Borshoff & Associates**

Brian J. Borshoff, LUTCF
P.O. Box 104
Carmel, Indiana 46082

Phone: (317) 846-1005
Fax: (317) 846-0983
Email: brian@borshoff.com
Web Site: www.borshoff.com

INDIVIDUAL LIFE INSURANCE PRESCREEN SHEET**Individual Information**

Name	Gender	Date of Birth MM/DD/YYYY	Height	Weight	Smoker?
	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No

Address Information**Phone Information**

Address		Home Phone	
City		Work Phone	
State		Fax	
Zip		Other (_____)	

Life Insurance Options

Total Coverage Option	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/>
Length of Coverage	<input type="checkbox"/> 1 year <input type="checkbox"/> 5 years <input type="checkbox"/> 10 years <input type="checkbox"/> 15 years <input type="checkbox"/> 30 years <input type="checkbox"/>
Type of Coverage	<input type="checkbox"/> Term <input type="checkbox"/> Permanent



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Medical History

1. Within the last 5 year have you:	Yes	No
a. Consulted any doctor, counselor or therapist?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been hospitalized or undergone any medical testing or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
c. Been advised of the need for any future treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently pregnant? Due Date: ____ / ____ / ____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking medication?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you filed any claims over \$2,000 within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>

FOR ANY "YES" ANSWERS IDENTIFIED ABOVE, PLEASE PROVIDE COMPLETE DETAILS.

Q #	Person	Illness and or Diagnosis	Dates		Type of Treatment or Surgery	Medication	Dosage
			From	To			

Detail and Additional Comments: