

Request for a Quotation of Life Insurance

US Life insurance companies calculate on an individual basis. It is therefore important that you reply to the questions carefully. In this way, you can benefit from the advantages of the best offer. Please note that we have had succesful experience in obtaining life insurance coverage for proposed insured's with a history of even serious medical ailments, including a history of heart disease and cancer. We can usually obtain coverage for proposed insured's up to and including age 89.

The answers to the questions below will be used to make the most precise quotation possible. Should any questions not be completed, the quotation will be made based on the infomation provided.

Please note that the fields below apply only to the proposed insured:

| | | |
|--|--|---|
| Date (dd.mm.yyyy) | | <input style="width: 150px;" type="text"/> |
| Surname of proposed insured | | Male <input type="checkbox"/> Female <input type="checkbox"/> |
| <input style="width: 150px;" type="text"/> | First name(s) of the proposed insured | Street, No. |
| <input style="width: 150px;" type="text"/> | Postal Code, City | <input style="width: 150px;" type="text"/> |
| <input style="width: 150px;" type="text"/> | Telephone (including country code) | Country of residence |
| <input style="width: 150px;" type="text"/> | Date of Birth (dd.mm.yyyy) | <input style="width: 150px;" type="text"/> |
| <input style="width: 150px;" type="text"/> | Citizenship(s) | Country of Birth |
| <input style="width: 150px;" type="text"/> | | Daily occupational duties |
| <input style="width: 150px;" type="text"/> | | <input style="width: 150px;" type="text"/> |
| <p>Have you travelled to any country outside the EU or Switzerland during the past 24 months?</p> <p>No <input type="checkbox"/> Yes. List the duration of travel, country and purpose</p> <p><input style="width: 150px;" type="text"/></p> | | |
| <p>Please note that on application for life insurance a clear copy of every page of your passport will be required so that the insurance company can verify travel by stamped entries</p> | | |
| Required Life Coverage | Term of life coverage | |
| <input style="width: 150px;" type="text"/> | <input style="width: 150px;" type="text"/> | |
| Reason for coverage | | |
| <input style="width: 150px;" type="text"/> | | |
| Beneficiary(ies) | | |
| <input style="width: 150px;" type="text"/> | | |
| Health questions for the proposed insured | | |
| Your weight in kg | <input style="width: 100px;" type="text"/> | Your height in cm |
| <input style="width: 100px;" type="text"/> | | <input style="width: 100px;" type="text"/> |
| Do you use tobacco in any form | When did you smoke last? | |
| No <input type="checkbox"/> Yes <input type="checkbox"/> | <input style="width: 150px;" type="text"/> | |
| What is your typical blood pressure? (With or without details of treatment if known) | | <input style="width: 150px;" type="text"/> |
| | | / |

| | | |
|---|--------------------------|---|
| What is your cholesterol level? (With or without details of treatment if known) | | <input type="text"/> |
| What is your CHOL / HDL ratio? (If known) | | <input type="text"/> |
| Do you participate in hazardous sports or are you an aircraft pilot? | | |
| No | <input type="checkbox"/> | Yes, and I participate in <input type="text"/> |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1.) Are both of your parents still alive? At which age did they die? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Was death preceded with long term illness? <input type="text"/> What were the complaints? <input type="text"/> Please indicate the year of birth of living parent(s) <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 2.) Have your parents or brothers / sisters ever had coronary artery disease, internal cancer or melanoma or cardiovascular disease prior to their age 60? If yes, which disorder? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 3.) Are you currently receiving any medical treatment and if yes, for what reasons? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 4.) Are you currently taking medication? Which? <input type="text"/> Since when do you take this medication? <input type="text"/> Which doctor prescribed you the medication? <input type="text"/> What is the dosage and frequency of this medication? <input type="text"/> Since when do you take the current dosage? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 5.) Have you ever been treated by a physician within the past 5 years? If yes, when and for which reasons <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 6.) In the past 5 years, have you ever had tests performed, have you been operated on or been treated? If yes, for which reasons? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 7.) In the past 5 years, have you ever been treated in hospital? If yes, for which reasons? <input type="text"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| Additional information: | | |
| <input type="text"/> | | |