SDPEBA Life Insurance Comparison Request

Please fax or email us the following form and we will begin researching appropriate carriers and plans for you to compare to your current plan. This is

To:	Will Stover	**From:**	
Fax:	619-431-4130	**Pages:**	
Phone:	619-535-7240	**Date:**	
Re:	Life Insurance Quote	**Phone:**	
E:	will@sdpeba.org	**Email:**	

completely confidential and will not be used for any other purpose.

DOB: ________________ AMOUNT OF CURRENT COVERAGE: ______________________________

SEX: ________________ CURRENT INSURANCE COMPANY_________________________________

HT & WT: ________________CURRENT PREMIUMS AMOUNT______________________________

TOBACCO USE: ______HOW OFTEN AND TYPE____

FAMILY HISTORY OF: CANCER, DIABETES OR HEART DISEASE/DEATH? (Immediate family only) (Give Details only if diagnosed B4 age 60)

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DO YOU HAVE MORE THAN TWO MOVING TRAFFIC VIOLATIONS IN THE PAST 2 YEARS?

____

ANY SIGNIFICANT MEDICAL HISTORY OR CONDITIONS?

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____

MEDICATIONS:

____

HAVE YOU BEEN HOSPITALIZED IN PAST 5 YEARS?_________

DETAILS: ____

BP______________________ CHOLESTEROL ____