# Pre-Qualifying Client Data Summary Sheet

**Please complete all fields and fax or e-mail to ICB when complete.**

**Fax: 973-361-0047/ E-mail: info@ica-icb.com**

Client Name: _____Agent Name: _____Agent Phone/E-mail: _____

Date of Birth: _____ Resident State: _____Carrier (s) Requested: _____

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1. Does your client use tobacco? ☐Yes ☐No If no, did your client use tobacco in the past? ☐Yes ☐No If so, when was the last time?_____

2. What is your client's current medical condition(s) and how are they treated?

3. Has the treatment changed in anyway the last year? ☐Yes ☐No If so, how?

4. Current medications, dosage, and reason for prescription?

| Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

5. Any conditions other than above that your client has been treated for in the last 5 years? ☐Yes ☐No If so, what?

6. Any hospitalizations in the last 5 years? ☐Yes ☐No If so, when and for what?

7. Any functional limitations? ☐Yes ☐No If so, what?

8. Is your client currently on Disability? ☐Yes ☐No If so, what kind? (SSDI, private, worker's comp, etc.)

9. Any surgery recommended, but not yet performed? ☐Yes ☐No If so, what?

10. Has your client's weight been consistent the last 6 months? ☐Yes ☐ No What is your client's current height? _____ weight? _____

11. If your client has any of the following conditions, please click on the appropriate link.

**Arthritis ■ Asthma ■ Diabetes ■ Crohn's Disease ■ Cancer ■ Bipolar ■ Degenerative Disc Disease ■ Fibromyalgia ■ Neuropathy ■ Osteoporosis**

***Disclaimer: Pre-Qualification is not a guarantee of insurance. It is simply providing the above information to the carrier who will consider your clients application.***