WESTLAND
FINANCIAL SERVICES INC

Life Insurance Quote Request

Please fax request to (888) 238-8154
or email info@westlandinc.com

Date _____ Agent Name _____

Agent Phone _____ Agent Email: _____

Insured Name _____ ☐ Male ☐ Female Date of Birth _____

Insured Address _____ City _____ State _____ Zip _____

Occupation _____ How Long? _____ Income _____

Product: ☐ Term ☐ ROP Term ☐ WL ☐ UL ☐ Index UL ☐ VUL ☐ SUL ☐ SVUL

Foreign Travel Plans (when, where, why and how long? _____

Aviation/Avocation: In the past 5 years, have you or do you intend to:

☐ None ☐ Flying ☐ Racing ☐ Sky Dive ☐ Scuba ☐ Other _____

Driving History: Have you had any of the following in the last 10 years?

☐ Moving Violation ☐ Reckless Driving ☐ DWI/DUI ☐ License Suspension/Revoked

Provide Dates and Details: _____

Nicotine: Present Use: ☐ None ☐ Cigarettes # Per Day Numer ☐ Cigars ☐ Pipe ☐ Dip ☐ Chew
☐ Nicotine Gum ☐ Other

Former Use: ☐ None ☐ Cigarettes # Per Day Numer ☐ Cigars ☐ Pipe ☐ Dip ☐ Chew
☐ Nicotine Gum ☐ Other Date of Last Use _____

Build: Height _____ Weight _____

Do you have a history of: ☐ High Blood Pressure What medication are you taking? _____

☐ High Cholesterol What medication are you taking? _____

Family History:	Age (age at death)	History of Heart Disease		History of Cancer	
Mother		☐ Yes	☐ No	☐ Yes	☐ No
Father		☐ Yes	☐ No	☐ Yes	☐ No
Sister(s)		☐ Yes	☐ No	☐ Yes	☐ No
Brothers		☐ Yes	☐ No	☐ Yes	☐ No

If yes to any of the above, provide details

Medical History: Have you had, been told had, or been treated for:

☐ Alcohol Abuse	☐ Depression	☐ Kidney Disease
☐ Alzheimer's/dementia	☐ Diabetes	☐ Lupus
☐ Asthma	☐ Drug Abuse	☐ Multiple Sclerosis
☐ Cancer	☐ Epilepsy	☐ Peripheral Vascular Disease
☐ Cirrhosis	☐ Heart Murmur/Valve Disease	☐ Sleep Apnea
☐ COPD	☐ Hepatitis	☐ Stroke
☐ Coronary/Vascular Disease	☐ Irregular Heartbeat/Palpitations	☐ Other

If yes, list dates, diagnosis, details, treatment and contact information on all physicians