

BALBOA LIFE AND CASUALTY
3349 Michelson Drive, Suite 200, Irvine, CA 92612-8893

SHORT FORM

INSURANCE COMPANY NAME		CITY		STATE
DISTRICT AGENCY - AGENCY NAME OR NUMBER				
NAME OF REQUESTOR				
NAME OF APPLICANT	LAST	FIRST	MIDDLE INITIAL	BIRTHDATE (MO/DAY/YR)
				AGE
AMOUNT APPLIED FOR: \$	TYPE INSURANCE INDIVIDUAL LIFE <input type="checkbox"/>		DISABILITY <input type="checkbox"/>	GROUP LIFE <input type="checkbox"/>
HEALTH <input type="checkbox"/>				

1. What is the name and address of your personal physician? _____
2. When did you last consult a physician? _____
3. What were your symptoms or complaints? _____
4. What was the diagnosis? _____
5. What treatment or medication prescribed? Any current medication used? _____
6. Do you use tobacco in any form.... Yes No Have you used tobacco in any form in the past and quit?.... Yes No
- If "Yes" what? Cigarettes Cigars Chewing Snuff Pipe If "Yes" when was last usage? _____
- Daily usage quantity _____ How many years used? _____

The foregoing answers are true and complete to the best of my knowledge, and shall become a part of my application to _____ Company.

DATE	SIGNATURE (PROPOSED INSURED)	SOCIAL SECURITY NUMBER/DRIVERS LICENSE#
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1. Height (in flat shoes): _____ Ft. _____ in. Other: _____
2. Weight (clothed): _____ Lbs. Is specimen being sent? Yes No
3. Blood Pressure: (right arm while seated) Two readings are recorded, none disregarded. If systolic over 140 or diastolic over 90, take 3rd and 4th readings after 10 min. rest.
- Systolic 1st 2nd 3rd 4th
- Diastolic _____ _____ _____ _____
- 5th (Phase) _____ _____ _____ _____
4. Pulse rate (at rest). Record for one full minute _____ Per /Min.
- Irregularities..... _____ Per/Min.
5. MALES ONLY
- Chest (Full Inspiration) Chest Forced Expiration Abdomen, at Umbilicus
- _____ in. _____ in. _____ in.
6. Urinalysis: Albumin _____ Sugar _____
7. Blood sample sent? Yes No
8. Oral fluid sent? Yes No
9. Was the paramedical conducted in the English language? Yes No
- If no, complete the following:
- a. Was an interpreter used? Yes No
- b. What language was used? _____
- c. What is the interpreter's relationship to the proposed insured? _____
10. ECG (attached) Yes No
11. TVC (attached) Yes No
12. Did you observe any obvious mental or physical abnormalities or any other factor significant to the morbidity/mortality of the applicant? Yes No

This report was completed at: Office Applicants Home Applicants Office Other (Specify) _____

In _____ this _____ day of _____, 20____ at _____ AM PM

REMARKS	SIGNATURE OF EXAMINER OR TECHNICIAN	TITLE
	AFFIX ADDRESS & TELEPHONE # STAMP HERE	