symmetry FINANCIAL GROUP | Powered by QUILITY

Client Qualification Form

GENERAL INFORMATION

CLIENT	SPOUSE/OTHER
Name:	Name:
Date of Birth: Age:	Date of Birth: Age:
Height: Weight:	Height: Weight:
Tobacco use? Y or N	Tobacco use? Y or N

MEDICAL CONDITIONS

high blood pressure | heart condition(s) | sleep apnea | stroke | cancer | diabetes (oral/insulin) | diseases

CLIENT	SPOUSE/OTHER
COVID-19 STATUS • Ever tested positive for COVID? Y or N • Date of positive result: • Date of negative result:	**COVID-19 STATUS** • Ever tested positive for COVID? Y or N • Date of positive result: • Date of negative result:
➔ **DIABETES FOLLOW-UP** ← • Age at diagnosis: Last A1C reading: • Insulin or oral medication? • Any complications (e.g., neuropathy, nephropathy, insulin shock)?	➔ **DIABETES FOLLOW-UP** ← • Age at diagnosis: Last A1C reading: • Insulin or oral medication? • Any complications (e.g., neuropathy, nephropathy, insulin shock)?
➔ **HIGH BLOOD PRESSURE FOLLOW-UP** ← ➔ How many medications?	➔ **HIGH BLOOD PRESSURE FOLLOW-UP** ← ➔ How many medications?
➔ **MAJOR MEDICAL FOLLOW-UP** ← ➔ How long ago was last treatment?	➔ **MAJOR MEDICAL FOLLOW-UP** ← ➔ How long ago was last treatment?

MEDICATIONS

CLIENT	SPOUSE/OTHER
➔ **MEDICATION FOLLOW-UP** ← How much do you spend per month on prescriptions?	

OCCUPATIONAL INFORMATION

CLIENT	SPOUSE/OTHER
Occupation:	Occupation:
Do you currently have life insurance? Y or N	Do you currently have life insurance? Y or N
If yes, how much coverage? $	If yes, how much coverage? $

MORTGAGE INFORMATION

Loan Amount: $	Mortgage Company:
Mortgage Term Length:	Monthly Payment:

PRIMARY CONCERN

What do you want this coverage to do for you? What made you want to send this form back to us?