Mid Michigan Exams, LLC.

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Work Order

CLIENT

Name:

Address:

City: State: Zip:

Phone: Work: Ext:

Date of Birth: / / Last 4 Digit of SSN: Email:

Sex: Male: ☐ Female: ☐ Smoker: Yes ☐ No ☐

Notes:

POLICY

Term Life: ☐ Whole/UL Life: ☐ Disability: ☐ LTC: ☐

If the above is not specified- requirements will default as Std/ Traditional.

Ins. Co. Policy Number:

Total Cumulative Policy Amount $

☐ Vitals/Measurements ☐ Paramed ☐ Senior Supplement ☐ Saliva

☐ Blood ☐ EKG ☐ MD Exam ☐ Other

☐ Urine/HOS ☐ HIV Consent ☐ Treadmill EKG

AGENT

Agent: Agent Code: Phone:

Agency: Agency#

Address:

Brokerage:

Address:

Send Status RPTS to FAX: Email:

PLEASE SUBMIT ALL ORDERS VIA WEBSITE, FAX, PHONE, OR EMAIL