Pre-Underwriting

Questionnaire

Knowledge. Experience. Results.

Please answer all questions applicable to the client's medical history.

Producer Name ______________________ Phone ______________________ Fax ______________________

Client Name ______________________ Date of Birth ______________________ ☐ Male ☐ Female

Face Amount ______________________ Max Premium $ ______________ /yr. ☐ UL ☐ WL ☐ Term ☐ Survivorship

Does the client currently smoke cigarettes ☐ Yes ☐ No If no, did he/she ever smoke? ☐ Never ☐ Quit (date) ______________

Does the client currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum, etc.) ☐ Yes ☐ No

If yes, please provide details: ____

When did he/she last use any form of tobacco: __________(Month) _______(Year) Type used last: ______________________

Has the case been submitted to other companies in the last 12 months ☐ Yes ☐ No If yes, list companies, dates, and action taken

____

____

Date of last routine physical ____

Health Conditions	Medications

Height ______________ Weight ______________ Average weight change is past 12 months ______________________

Latest blood pressure reading ______________ Date ______________________

Cholesterol/HDL results ______________ Date ______________________

Family history: Has any family member had death or disease prior to age 60 from cancer, diabetes, high blood pressure, heart disease, or kidney disease? If yes, identify family member, disorder, and age at onset.

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☐ **Alcohol/Drug Abuse**

Current user ☐Yes ☐No Duration used__________ Date stopped using __________

Kind of substance__________ Amount used __________ Type of treatment __________

Attend AA or other programs ☐Yes ☐No Any relapses ☐Yes ☐No

Are liver functions normal ☐Yes ☐No If no, provide readings__________

Any motor vehicle violations or DUIs ☐ Yes ☐ No If yes, provide details__________

☐ **Asthma/COPD**

When diagnosed__________ Medication __________ Number of attacks per year__________

Date and severity of last attack__________ Are attacks seasonal ☐Yes ☐No

Any hospitalizations ☐Yes ☐No If yes, when__________

☐ **Aviation**

Hours flown as pilot or co-pilot__________ Hours flown solo__________ Hours flown per year__________

Type of license__________ Purpose (civilian, military, etc.)__________

☐ **Cancer**

Type__________ Location__________ Staging__________

Grading or copy of pathology report__________ Any positive lymph nodes ☐Yes ☐No

Depth, level, or Gleason Score__________ Date of surgery__________

Any radiation or chemo ☐Yes ☐No If yes, date treatment ended __________

Any recurrence of cancer ☐Yes ☐No If yes, provide details __________

Any other medical problems ☐Yes ☐No If yes, provide details__________

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☐ **Cardiac Disorders**

Any History Of?	Date of Onset	Treatment Given
☐ Angina (chest pain)	______	______
☐ MI (heart attack)	______	______
☐ Irregular heart beat	______	______
☐ Valve disorder	______	______
☐ Coronary artery disease	______	______

Date of last cardiologist visit ______ Reason ______

Date of most recent stress test ______ Results ______

Date of most recent echocardiogram ______ Results ______

Ever Have?	Date	Results	
☐ Coronary catherization	______	______	
☐ Bypass surgery (CABG)	______	______	# of vessels ______
☐ Angiplasty (PTCA)	______	______	# of vessels ______
☐ Valve surgery or replacement	______	______	which valve ______

Current symptoms

☐ Chest pain How often ______ ☐ Pressure How often ______

☐ Dizziness How often ______ ☐ Blackouts How often ______

☐ Shortness of breath How often ______

What medications (including over-the-counter) is the client taking

Does the client carry nitroglycerin ☐ Yes ☐ No Date of last usage ______

Copies of the catherization reports, stress tests, and echocardiograms will assist in evaluation the client's history.

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☐ **Crohns** ☐ **Colitis**

Date diagnosed________________ Any hospitalizations or surgery ☐ Yes ☐ No If yes, what____________________________

Current medications____ Date of last episode________________________

☐ **Diabetes**

Date diagnosed________________ Treatment (oral meds, insulin, diet)________________________ Units of insulin __________

Names of medications ____

Number of regular doctor visits per year____

Any other medical impairments of complications____

Last fasting blood sugar and date _________________________ Last glycohemoglobin and date ______________________________

☐ **Foreign Travel/Foreign Residence**

Citizenship_____________________ Type of Visa____________________ Does client have a green card ☐ Yes ☐ No

Answer the following if the client is not a US citizen

How long in the US_____________ Works in the US ☐ Yes ☐ No Owns property in the US ☐ Yes ☐ No
US bank account ☐ Yes ☐ No

Travel outside the US

Country	City	Duration of Stay	Frequency	Purpose of Travel

☐ **Hepatitis**

Type ☐ A ☐ B ☐ C Date diagnosed________________ Cause ____

Current status ☐ Active ☐ Cured Medications/date of last use ____

Current alcohol use/amount____

☐ **Hypertension**

Date diagnosed________________ Average readings_______________ Are readings monitored at home ☐ Yes ☐ No

Medications ____

Any other impairments____

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☐ **Lab Abnormalities**

What tests were abnormal ______________________ Results/date(s)______________________

Any diagnosis given ______________________ How long has test been abnormal______________________

☐ **Multiple Sclerosis** ☐ **Lupus**

Date diagnosed______________ Last attack______________ Attack frequency______________

How long do attacks last______________ Any disability______________________

Current medications______________________ Previous medications______________________

☐ **Mental Disorders/Depression/Anxiety**

Diagnosis______________________________________ Date______________

Medication______________________________________

Hospitalization ☐Yes ☐No Suicide attempt(s) ☐Yes ☐No Currently employed ☐Yes ☐No

☐ **Seizure Disorder/Epilepsy**

Date of last seizure______________ Date of diagnosis______________ Type of seizure______________

Frequency of seizures______________ Medications______________________

☐ **Sleep Apnea**

Date diagnosed______________ Is CPAP used every night ☐Yes ☐No Date of last sleep study______________

Sleep study results ☐Mild ☐Moderate ☐Severe Was surgery done ☐Yes ☐No If yes, type ______________

☐ **TIA/CVA (transient ischemic attack-ministroke/stroke)**

Date of episode______________ Number of episodes______________ Any residuals______________

Type of treatment/medication______________________________________

☐ **Avocations (scuba, mountain climbing, etc.**

Specify______________________________________

☐ **Impairments not listed**

Diagnosis given______________________________________ Date______________

Treatment______________________ Medications______________________

Date of last follow-up______________________ Test results______________________

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