

# Underwriting Questionnaire

## Pre-Underwriting



This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

### PRODUCER INFORMATION (this section must be completed)

Name		Producer Number	
Phone		Email Address	
Have you submitted this case previously? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### CLIENT HISTORY (this section must be completed)

Client Name			State	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	Height	Weight
Average weight change in the past 12 months			Occupation	
Is the client a Foreign National? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list country of citizenship		
Has the client traveled outside the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list the countries and dates visited		
Green Card? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Type of Visa				

### REQUESTED COVERAGE (this section must be completed)

<input type="checkbox"/> Universal Life <input type="checkbox"/> Survivorship <input type="checkbox"/> Variable Life <input type="checkbox"/> Whole Life <input type="checkbox"/> LTC Rider <input type="checkbox"/> Term, Level Period _____	
Face amount desired?	If you are replacing coverage, will there be any 1035 money with this replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what amount will be carried over? _____
Has the case been submitted to other companies in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list companies, dates, and action taken	

### TOBACCO/NICOTINE USAGE (this section must be completed)

Has your client ever smoked cigarettes: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last usage: _____	
Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide types and last date of use: _____	

### MARIJUANA & CBD OIL USAGE (this section must be completed)

Does your client use marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	
Purpose <input type="checkbox"/> Recreational/Social <input type="checkbox"/> Medicinal	Frequency _____ times per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year
Delivery Method <input type="checkbox"/> Ingested <input type="checkbox"/> Vaporized <input type="checkbox"/> Inhaled	Date Last Used _____
Does your client use CBD oil? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:	
Frequency _____ times per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	
Delivery Method <input type="checkbox"/> Ingested <input type="checkbox"/> Vaporized <input type="checkbox"/> Topical	Date Last Used _____



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### MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your client's primary care physician? When did your client last consult him/her? Any ongoing medical treatment?			
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

### FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below.  Yes  No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

### DRUG AND ALCOHOL USAGE check here if this section is not applicable

Does your client currently drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your client ever drank substantially more than present? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type(s) of Alcohol _____	If yes, when? _____
Date of last consumption _____	Has your client ever consulted a doctor or received treatment because of alcohol use?
How much per week _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details _____
Has your client ever used illegal drugs or sought treatment because of drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details _____	
Type of drug(s) used _____	Date of last use _____

### CORONARY check here if this section is not applicable

Date of diagnosis or first chest pain	Number of diseased vessels	
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)		
Date of last stress EKG	Results	By whom?
Any pain since treatment/surgery?		

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<b>CANCER</b> <input type="checkbox"/> check here if this section is not applicable	
Exact name and location of cancer	Stage and grade
Who would have the pathology report	Date/details of treatment/surgery

<b>DIABETES</b> <input type="checkbox"/> check here if this section is not applicable			
Date of diagnosis	Treatment <input type="checkbox"/> Diet only <input type="checkbox"/> Oral medication <input type="checkbox"/> Insulin	Details	
Does your client regularly test his/her blood glucose? <input type="checkbox"/> Yes <input type="checkbox"/> No	Results	Frequency	
Latest result of glycohemoglobin (A1C) test _____ mg%		Date _____	
Has your client been diagnosed with having protein and/or microalbumin in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your client ever had:	Eye trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Have your client ever had:	Kidney trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Neuritis/Neuralgia <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin reactions <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>MENTAL DISORDERS/DEPRESSION/ANXIETY</b> <input type="checkbox"/> check here if this section is not applicable			
Date of diagnosis	Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide attempt(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently employed <input type="checkbox"/> Yes <input type="checkbox"/> No
Medications			

<b>SLEEP APNEA</b> <input type="checkbox"/> check here if this section is not applicable		
Date of diagnosis	Is a CPAP used every night <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last sleep study
Sleep study results <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Was surgery done <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of surgery

<b>HAZARDOUS ACTIVITIES</b> <input type="checkbox"/> check here if this section is not applicable			
Is your client a private pilot? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details.	How many total hours has your client flown as Pilot in Command? _____	How many hours does your client fly per year? _____	Does your client have an IFR (instrument flight rating) <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your client participate in the following activities? (check those that apply)			
<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Ultralight Flying	<input type="checkbox"/> Sky Diving
<input type="checkbox"/> Mountain Climbing	<input type="checkbox"/> Hang Gliding	<input type="checkbox"/> Auto/Motorcycle Racing	<input type="checkbox"/> Other _____

<b>DRIVING HISTORY</b> <input type="checkbox"/> check here if this section is not applicable			
DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Multiple Sclerosis, TIA/CVA, etc.)? If so, please describe below and include additional pages if more space is needed.

Impairment Not Listed	Date of Diagnosis	Treatment Medication(s)	Date of Last Follow-Up Test Results