# Pre-Underwriting

## Questionnaire

Knowledge. Experience. Results.

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

Producer Name_____ Phone _____ Date_____

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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