

HEALTH / LIFE INSURANCE UNDERWRITING QUESTIONNAIRE

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|--|-----------------|-----------------------------|--------------------|
| Client Name: | | Height: _____ ft. _____ in. | Weight: _____ lbs. |
| D.O.B.: | State of Birth: | Phone: _____ | |
| Purpose for Insurance: <input type="checkbox"/> Estate Protection <input type="checkbox"/> Term is Expiring <input type="checkbox"/> Insurance Policy Rescue <input type="checkbox"/> Business Buy/Sell | | | |
| <input type="checkbox"/> Other: _____ _____ _____ | | | |

LIFESTYLE & HEALTH QUESTIONS

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| 1. Within the last 12 months, has anyone to be covered been declined for medical reasons on any life insurance application? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you use marijuana or tobacco products (includes smoking, chewing, other applications of THC or nicotine)? If YES , please specify what product(s), how often used, and for how long you have used it: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Within the last five years, has anyone to be covered been convicted of a felony, been charged two or more times with operating a vehicle while under the influence of alcohol or drugs, been charged five or more times with a moving violation, or is currently on parole or incarcerated in a correctional institution? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Within the last 12 months, has anyone to be covered been charged with operating a vehicle while under the influence of alcohol or drugs or does anyone to be covered currently have a suspended or revoked driver's license? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for major depression, bipolar disorder; schizophrenia; or a suicide attempt, or been confined in a hospital or a mental or psychiatric facility within the last 12 months for any mental or nervous disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol or Drug Abuse, Treatment for Alcohol or Drug Use, DUI/Citation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Disease, Disorder or Abnormality of The Circulatory System, Including, But Not Limited To, Stroke, TIA, Arterial Blockage, or Cerebral Vascular Insufficiency. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Disease, Disorder, or Abnormality of The Heart Including, But Not Limited To, Cardiomyopathy, Heart Attack, or Congenital Heart Disease (Excluding Surgically Corrected Atrial Septal Defect), Heart Surgery, Atrial Fibrillation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Treated with Insulin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/TIA |
| 7. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Artery Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes (Type I or II) (Excluding Gestational) |

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| <p>8. In the last two years, has anyone to be covered been advised by a member of the medical profession to undergo a procedure, test, analysis, surgery, or study that has not been scheduled, is scheduled but not yet performed, or has been performed but the results of which are not yet known? (Examples: MRI, biopsy, heart stress, blood/urine, sleep study, etc.)</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| <p>9. Are there any other medical conditions not listed above?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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DETAILS TO "YES" ANSWERS FOR QUESTIONS 6-8

| Question Number | Name of Medical Condition | Onset (MO/YR) | Procedure or Surgery Performed or Recommended? (If yes, provide type of procedure, date.) | Hypertension and Diabetes, List Average Reading (for prior 3 months) |
|-----------------|---------------------------|---------------|---|--|
| Q: _____ | | | | |
| Q: _____ | | | | |
| Q: _____ | | | | |
| Q: _____ | | | | |
| Q: _____ | | | | |
| Q: _____ | | | | |
| Q: _____ | | | | |

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| <p>10. Within the last six weeks, has anyone to be covered been prescribed or taken any medication recommended by a Physician (not including prescription contraceptives)? If YES, please provide complete information below:</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Name of Medication | Taken for What Condition? | Dosage & Frequency | Date First Prescribed |
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