Underwriting Questionnaire
Chronic Pain

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

☐ Male ☐ Female Face Amount _____ Max Premium $ _____ /yr.

☐ Term ☐ Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

What medical condition or impairment is the source of the chronic pain _____ Date of onset _____

If due to injury, describe how the client was injured and symptoms experienced as a result _____

_____

Is narcotic pain medication taken ☐ Yes ☐ No If yes, advise name of the medication(s), dosage(s) and frequency taken _____

_____

Is the client prescribed medical marijuana ☐ Yes ☐ No If yes, advise prescription details to include how much and how often it is used and method (smoked, ingested, drops, etc.) _____

Has the client ever used more medication then what is prescribed ☐ Yes ☐ No If yes, provide details _____

_____

Will the client be on narcotic pain medication long term or is this use temporary _____ If temporary, when does he/she expect to be off medication _____

How often does the client see his/her doctor or pain management specialist _____

Is the client significantly impaired in a normal day-to-day activities ☐ Yes ☐ No If yes, advise what limitations the client has

_____

On a pain scale of 1 to 10, how does the client describe his/her level of pain (circle a number) very mild 1 2 3 4 5 6 7 8 9 10 severe

Does the client attend support groups and/or chronic pain rehabilitation program such as physical therapy or other ☐ Yes ☐ No
If yes, provide details _____

What is the client's occupation _____ Is the client currently working ☐ Yes ☐ No

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Is the client on disability ☐Yes ☐No If yes, date he/she went on disability_____

Is the disability going to be ☐permanent or ☐temporary If temporary, advise approximate duration of disability_____

Has the client ever had a history of anxiety, depression, or other mental health condition ☐Yes ☐No If yes, provide full details

_____

Has the client ever had a history or drug or alcohol abuse ☐Yes ☐No If yes, provide full details_____

_____

Does the client currently drink alcohol ☐Yes ☐No If yes, provide amount per sitting and frequency of use_____

_____

Does the client use any recreational drugs ☐Yes ☐No If yes, advise type and frequency of use_____

_____

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: