Underwriting Chronic P	g Questionnaire Pain		Under Millings
Producer Name	Phone	Date	
Client Name	Date of Birth		
Male Female	Face Amount Max F	'remium \$ /yr.	
□ Term □ Permanent	Has the client ever used any form of tobacco (cig	arettes, cigars, pipe, snuff, etc.	)? 🗆 Yes 🔲 No
Frequency	Date of last use	Туре	
What medical condition or ir	npairment is the source of the chronic pain		Date of onset
If due to injury, describe how	the client was injured and symptoms experienced a	s a result	
Is the client prescribed medic used and method (smoked, i	aken Yes No If yes, advise name of th al marijuana Yes No If yes, advise pre ngested, drops, etc.)	escription details to include how	much and how often it is
	pain medication long term or is this use temporary_ cation		If temporary, when does
How often does the client se	e his/her doctor or pain management specialist		
ls the client significantly impa	aired in a normal day-to-day activities Yes N	o If yes, advise what limit	ations the client has
On a pain scale of 1 to 10, h	ow does the client describe his/her level of pain (circl	very mild e a number)1 2 3 4	severe 5 6 7 8 9 10
	ort groups and/or chronic pain rehabilitation program		er Yes No
What is the client's occupation	on	_ Is the client currently workir	ng Yes No

## **CBS** | BROKERAGE

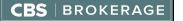
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## Underwriting Questionnaire Chronic Pain

he client on disability Yes No If yes, date he/she went on disability							
s 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				

Name of Medication (prescription or otherwise)	Dates Used	Quantity laken	Frequency Taken
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List any other major health problems the client has:



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