Underwriting Questionnaire
Gastric Bypass

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 _____

Date of procedure _____ Type of procedure (e.g. gastric bypass, banding, etc.) _____

Weight prior to procedure _____ Current weight _____ Has weight loss been stable/maintained ☐ Yes ☐ No

Height _____

Select and provide details if any of the following complications have occurred

- ☐ Hemorrhage _____
- ☐ Obstruction _____
- ☐ Perforation _____
- ☐ Leaks _____
- ☐ Abnormal liver function studies _____
- ☐ Hypoglycemia _____
- ☐ Anemia _____
- ☐ Nutritional deficiencies _____
- ☐ Vomiting or nausea _____
- ☐ Change in bowel habits/diarrhea due to dietary modifications _____
- ☐ Failure to lose weight _____
- ☐ Problems retaining weight _____
- ☐ Dumping syndrome _____

Any history, past or present, of associated chronic disease including diabetes, hypertension, hyperlipidemia, obstructive sleep apnea, or cardiovascular disease? ☐ Yes ☐ No If yes, provide details below

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

List any other major health problems the client has:

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