Underwriting Questionnaire

Gastric Bypass



Producer Name	_ Phone		Date		
Client Name	Date of Birth				
☐ Male ☐ Female Face Amount		Max Premiun	n \$	/yr.	
☐ Term ☐ Permanent Has the client ever	used any form of tob	acco (cigarettes	, cigars, pipe, sr	uff, etc.)?	′es □No
Frequency	Date of last use		Тур	e	
Date of procedure Type	of procedure (e.g. ga	stric bypass, ba	nding, etc.)		
Weight prior to procedure Current weig	jht Has v	veight loss beer	stable/maintair	ned □Yes □]No
Height					
Select and provide details if any of the following cor Hemorrhage Obstruction Perforation Leaks Abnormal liver function studies Hypoglycemia Anemia Nutritional deficiencies Vomiting or nausea Change in bowel habits/diarrhea due to di Failure to lose weight Problems retaining weight Dumping syndrome	etary modifications				
Any history, past or present, of associated chronic di cardiovascular disease? □Yes □No If yes, pro		etes, hypertension	on, hyperlipidem	ia, obstructive	sleep apnea, or
Name of Medication (prescription or otherwise	e) Dates	Used	Quantity Ta	ken	Frequency Taken

List any other major health problems the client has:



For Insurance Professional Use Only. Not intended for use in solicitation of sales to the public. Not intended to recommend the use of any product or strategy for any particular client or class of clients. For use with non-registered products only. Tellus operates under the license of Tellus Brokerage Connections Inc., AR license #100103477. Products and programs offered through Tellus are not approved for use in all states. Updated May 12, 2020