



Pre-Underwriting

Please answer all questions applicable to the client's medical history.

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 _____

Has the case been submitted to other companies in the last 12 months Yes No If yes, list companies, dates, and action taken

Date of last routine physical _____

Health Conditions	Medications (including over-the-counter)

Height _____ Weight _____ Average weight change is past 12 months _____

Latest blood pressure reading _____ Date _____

Cholesterol/HDL results _____ Date _____

Family history: Has any immediate family member (parents or siblings) had death or disease up to age 65 from cancer, diabetes, cerebrovascular disease, or heart disease? If yes, complete the information below.

Relation (Mother, Father, Brother, Sister)	Type of Disease	If Cancer, Type of Cancer	Age of Onset	Age at Death (If Deceased)



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Check the following and provide details if applicable.

Alcohol/Drug Abuse

Current user Yes No Duration used _____ Date stopped using _____

Kind of substance _____ Amount used _____ Type of treatment _____

Attend AA/NA or other programs Yes No Any relapses Yes No

Any motor vehicle violations or DUIs Yes No If yes, provide details _____

Asthma/COPD

When diagnosed _____ Number of attacks per year _____

Date and severity of last attack _____ Are attacks seasonal Yes No

Any hospitalizations Yes No If yes, when _____

Aviation

Total hours flown as pilot or co-pilot _____ IFR? _____ Hours flown per year _____

Type of license _____ Purpose (civilian, military, etc.) _____

Cancer

Type _____ Location _____ Staging _____

Grading or copy of pathology report _____ Any positive lymph nodes Yes No

Depth, level, or Gleason Score _____ Date of surgery _____

Any radiation or chemo Yes No If yes, date treatment ended _____

Any recurrence of cancer Yes No If yes, provide details _____



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Cardiac Disorders

Any History Of?

Date of Onset

Treatment Given

MI (heart attack)

Irregular heart beat

Valve disorder

Coronary artery disease

Date of last cardiologist visit _____ Reason _____

Date of most recent stress test _____ Results _____

Date of most recent echocardiogram _____ Results _____

Ever Have?

Date

Results

Coronary catheterization

Bypass surgery (CABG)

_____ # of vessels _____

Angioplasty (PTCA)

_____ # of vessels _____

Valve surgery or replacement

_____ which valve _____

Stenting

_____ which vessel(s) _____



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Crohns Colitis

Date diagnosed _____ Any hospitalizations or surgery Yes No If yes, what _____

Diabetes

Date diagnosed _____ Treatment (oral meds, insulin, diet) _____ Units of insulin _____

Names of medications _____

Number of regular doctor visits per year _____

Any complications _____

Last fasting blood sugar and date _____ Last glycohemoglobin (A1c) and date _____

Foreign Travel/Foreign Residence

Citizenship _____ Type of Visa _____ Does client have a green card Yes No

Answer the following if the client is not a US citizen

How long in the US _____ Works in the US Yes No Owns property in the US Yes No
US bank account Yes No

Travel outside the US

Country	City	Duration of Stay	Frequency	Purpose of Travel
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Hepatitis

Type A B C Date diagnosed _____ Cause _____

Current status Active Cured Medications/date of last use _____

Current alcohol use/amount _____

Hypertension

Date diagnosed _____ Average readings _____ Are readings monitored at home Yes No



Pre-Underwriting

Lab Abnormalities

What tests were abnormal _____ Results/date(s) _____

Any diagnosis given _____ How long has test been abnormal _____

Multiple Sclerosis **Lupus**

Date diagnosed _____ Last attack _____ Attack frequency _____

How long do attacks last _____ Any disability _____

Mental Disorders/Depression/Anxiety

Diagnosis _____ Date _____

Hospitalization Yes No Suicide attempt(s) Yes No Currently employed Yes No

Seizure Disorder/Epilepsy

Date of last seizure _____ Date of diagnosis _____ Type of seizure _____

Frequency of seizures _____

Sleep Apnea

Date diagnosed _____ Is CPAP used every night Yes No Date of last sleep study _____

Sleep study results Mild Moderate Severe Was surgery done Yes No If yes, type _____

TIA/CVA (transient ischemic attack-ministroke/stroke)

Date of episode _____ Number of episodes _____ Any residuals _____

Type of treatment/medication _____

Avocations (scuba, mountain climbing, etc.)

Specify _____

Impairments not listed

Diagnosis given _____ Date _____

Treatment _____ Medications _____

Date of last follow-up _____ Test results _____