



OUR GOAL IS YOUR LEGACY EST. 2008 SHAKOPEE, MINNESOTA

HEALTH / LIFE INSURANCE UNDERWRITING QUESTIONNAIRE

Client Name:		Height: _____ ft. _____ in.	Weight: _____ lbs.
D.O.B.:	State of Birth:	Phone: _____	
Purpose for Insurance: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%;"> <input type="checkbox"/> Estate Protection <input type="checkbox"/> Term is Expiring <input type="checkbox"/> Insurance Policy Rescue <input type="checkbox"/> Business Buy/Sell </div> <div style="width: 35%;"> <input type="checkbox"/> Other: _____ _____ _____ </div> </div>			

LIFESTYLE & HEALTH QUESTIONS

1. Within the last 12 months, has anyone to be covered been declined for medical reasons on any life insurance application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you use marijuana or tobacco products (includes smoking, chewing, other applications of THC or nicotine)? If YES , please specify what product(s), how often used, and for how long you have used it: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last five years, has anyone to be covered been convicted of a felony, been charged two or more times with operating a vehicle while under the influence of alcohol or drugs, been charged five or more times with a moving violation, or is currently on parole or incarcerated in a correctional institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the last 12 months, has anyone to be covered been charged with operating a vehicle while under the influence of alcohol or drugs or does anyone to be covered currently have a suspended or revoked driver's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for major depression, bipolar disorder; schizophrenia; or a suicide attempt, or been confined in a hospital or a mental or psychiatric facility within the last 12 months for any mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol or Drug Abuse, Treatment for Alcohol or Drug Use, DUI/Citation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Disease, Disorder or Abnormality of The Circulatory System, Including, But Not Limited To, Stroke, TIA, Arterial Blockage, or Cerebral Vascular Insufficiency.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any Disease, Disorder, or Abnormality of The Heart Including, But Not Limited To, Cardiomyopathy, Heart Attack, or Congenital Heart Disease (Excluding Surgically Corrected Atrial Septal Defect), Heart Surgery, Atrial Fibrillation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes Treated with Insulin
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA
7. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Coronary Artery Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes (Type I or II) (Excluding Gestational)

<p>8. In the last two years, has anyone to be covered been advised by a member of the medical profession to undergo a procedure, test, analysis, surgery, or study that has not been scheduled, is scheduled but not yet performed, or has been performed but the results of which are not yet known? (Examples: MRI, biopsy, heart stress, blood/urine, sleep study, etc.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<p>9. Are there any other medical conditions not listed above?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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DETAILS TO "YES" ANSWERS FOR QUESTIONS 6-8

Question Number	Name of Medical Condition	Onset (MO/YR)	Procedure or Surgery Performed or Recommended? (If yes, provide type of procedure, date.)	Hypertension and Diabetes, List Average Reading (for prior 3 months)
Q: _____				
Q: _____				
Q: _____				
Q: _____				
Q: _____				
Q: _____				
Q: _____				

<p>10. Within the last six weeks, has anyone to be covered been prescribed or taken any medication recommended by a Physician (not including prescription contraceptives)? If YES, please provide complete information below:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of Medication	Taken for What Condition?	Dosage & Frequency	Date First Prescribed