



Pre-Screening Questionnaire

Proposed Insured: (full name) _____

Date of Birth _____ **Height** _____ **Weight** _____ **Nicotine Use** _____ **Type** _____

Please give complete details of all **YES** answers to questions, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, please use back of form.

Have you ever had, been told by a member of the medical profession that you have, or been diagnosed with or treated for:

1. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood? . . . Yes No
 2. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? Yes No
 3. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? Yes No
 4. Cancer, tumor, polyp or cyst? Yes No
 5. Any Physical deformity or amputation? Yes No
 6. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? Yes No
 7. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test? . . . Yes No
 8. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? Yes No
 9. Any moving violations, driving under the influence or driving while intoxicated, etc. in the past 10 years? Yes No
 10. Have any or your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? Yes No
 11. Has any application for life, health, disability, or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled, or non-renewed? Yes No
 12. Are you currently taking any prescriptions, vitamins, supplements or over-the-counter medications? Yes No
- If Yes, please list _____

Details:

FAMILY HISTORY:

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers #				
Sisters #				



Driesbach Financial Group, Inc.
9001 N. Wesleyan Road
Suite 110
Indianapolis, IN 46268

Phone: 800-229-8109
Fax: 317-876-6290

Email: abiech@indytrans.com

Pre-Screening Questionnaire

Agent Name: _____ **Agent Email:** _____

Agent Phone: _____ **Agent Fax:** _____

Plan applying for: **TERM** **Universal Life**

Face Amount: _____ **Term Period:** _____

Additional Comments: