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Pre-Screening Questionnaire

Proposed Insured: (full name) _____ Agent 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. If additional space is required, please use the back of this form.

Have you ever had, been told by a member of the medical profession that you have, or been diagnosed with or treated for:		Details:
1. High blood pressure, heart attack, heart murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Cancer, tumor, polyp or cyst? (If yes, please provide details)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Any physical deformity or amputation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Any immune deficiency disorder, AIDS, AIDS related Complex (ARC), HIV, or tested positive on an AIDS/HIV-related test?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. A. Any moving violations? B. Driving under the influence or driving while intoxicated, etc. in the past 10 years? (If yes, please include dates and violations)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have your parents, brothers, or sisters ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Are you currently taking any prescriptions, vitamins, supplements or over the counter medications? (If Yes, please list under details)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Are you going to be traveling outside of the United States in the next 2 years, business or pleasure? (If yes, advise destination(s), duration of stay, and purpose of travel)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Do you participate in any extreme sports? Underwater diving, Aerial Sports, Motor Sports (If yes, please provide details)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Are you a private pilot? (If yes, what type of plane, how many hours flown per year and total to date, what certifications do you hold)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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