



MANDATORY INITIAL QUESTIONNAIRE

Agent: _____ Phone: _____ Email: _____

Proposed Insured Name: _____ M F Date of birth: _____

Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

Has the proposed insured experience a change in weight greater than 10 lbs in the last 12 months?
 Yes / No If Yes, please specify pounds gained/lost and why: _____

***Do you currently have, or have you EVER had, a history of any of the following?
Please check ALL that apply and complete additional forms:***

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Alcohol / Drug Abuse / Treatment | <input type="checkbox"/> Criminal Record | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Artery / Vein / Heart Disorders | <input type="checkbox"/> Dangerous Avocation / Hobby | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's / Alzheimer's / Memory Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes / Elevated A1C | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate / Kidney / Bladder Disorders |
| <input type="checkbox"/> Asthma / Emphysema / Lung Disorders | <input type="checkbox"/> Driving Record | <input type="checkbox"/> Liver / Pancreas Disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Emotional / Psychological Disorders | <input type="checkbox"/> Liver Enzymes | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Foreign Travel | <input type="checkbox"/> Marijuana / CBD Use | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Brain / Nervous System Disorders | <input type="checkbox"/> Gastrointestinal / Digestive Disorders | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other: _____ _____ _____ |
| <input type="checkbox"/> Cancer / Tumor / Polyp | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Muscular / Bone / Joint Disorders | |

Please list all medications currently taken or taken in the last 10 years:

| Name of medication (prescription or otherwise) | Dates used | Dosage | Frequency taken |
|--|------------|--------|-----------------|
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Please provide any additional information: _____

