EMG
Insurance Brokerage

GENERAL MEDICAL QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ ☐ M ☐ F Birth or Age: _____

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: _____

Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____

Has the Proposed Insured experienced a change in weight greater than 10 pounds in the past 12 months?

☐ Yes ☐ No If YES, please specify: Pounds Lost/Pounds Gained Reason

_____

Has the Proposed Insured EVER been diagnosed by, or received treatment from, a licensed member of the medical profession for any of the following? If YES, please circle ALL that apply and provide details below.

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Cancer / Tumor / Polyp
- ☐ Asthma / Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Paralysis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Memory Loss
- ☐ Colitis
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Arthritis

_____

_____

_____

Other than as indicated above, has the Proposed Insured EVER been diagnosed by a licensed member of the medical profession with any disease or disorder of any of the following? If YES, please circle ALL that apply and provide details below.

- ☐ Heart
- ☐ Arteries / Veins
- ☐ Lungs / Respiratory System
- ☐ Gastrointestinal / Digestive System
- ☐ Liver / Pancreas
- ☐ Kidney / Bladder
- ☐ Prostate
- ☐ Reproductive Organs
- ☐ Brain / Nervous System
- ☐ Blood
- ☐ Lymph Nodes
- ☐ Immune System
- ☐ Thyroid/ Other Glands
- ☐ Eyes
- ☐ Ears / Nose / Throat
- ☐ Skin
- ☐ Muscles / Bones / Joints
- ☐ Emotional / Psychological Disorder

_____

_____

_____

Other than as indicated previously, within the past five years, has the Proposed Insured been diagnosed by any physician, practitioner or health facility as having had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility?

_____

_____

_____

Is the Proposed Insured currently receiving any treatment by a licensed member of the medical profession or taking any prescription or nonprescription medications or supplements?

_____

_____

_____

Does the Proposed Insured have any surgery, medical tests, treatment, or visits with a health professional scheduled in the next six months?

_____

Has the Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection?

_____

Has the Proposed Insured ever used cocaine, heroin, barbiturates, amphetamines, hallucinogens, or controlled substances except as prescribed by a health professional?

_____

Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a licensed member of the medical profession or support group?

_____

Has the Proposed Insured ever been arrested for driving under the influence (DUI) or for driving while intoxicated?

_____

To the best of your knowledge and belief, has a parent or sibling ever had: heart disease, coronary artery disease, vascular disease, stroke/cerebrovascular disease, diabetes, cancer, or kidney disease? If YES, please provide details below

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			