



An insurance Designers member since 1986

HEPATITIS QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

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.

(1) Please provide date of diagnosis: _____

(2) Has the Hepatitis been diagnosed as:

- | | |
|---|---|
| <input type="checkbox"/> Acute Viral Hepatitis A Resolved | <input type="checkbox"/> Hepatitis A Unresolved |
| <input type="checkbox"/> Acute Viral Hepatitis B Resolved | <input type="checkbox"/> Chronic Persistent Hepatitis B Unresolved (i.e. carrier) |
| <input type="checkbox"/> Acute Viral Hepatitis C | <input type="checkbox"/> Chronic Active Hepatitis B Unresolved |
| <input type="checkbox"/> Other Hepatitis: _____ | <input type="checkbox"/> Chronic Persistent Hepatitis C |
| | <input type="checkbox"/> Chronic Active Hepatitis C |

(3) What are the most current liver enzyme levels:

Date	GGTP	ALT/SGPT	AST/SGOT

(4) Which studies have been undertaken to diagnose/treat the condition:

- Liver ultrasound, CT scan, or MRI (circle which one): Date: _____ Results: Normal Abnormal
- Liver biopsy Date: _____ Results: Normal Abnormal
- Other: _____
- Studies Recommended/Pending: _____ Date Planned: _____

(5) Does the proposed insured use any medications, such as alpha interferon or ribavirin?

If yes, please complete the table below:

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

(6) Does the proposed insured consume any alcohol?

- No Yes Describe: _____ (type, frequency, quantity)

(7) How frequently does a physician monitor liver functions:

- Quarterly Semiannually Annually Other: _____

(8) If infected with hepatitis C, is the proposed insured vaccinated against: Hepatitis A Hepatitis B

(9) Please advise of any additional information that may help us provide you with a more accurate preliminary assessment:
