



CLIENT PRE-SCREEN QUESTIONNAIRE

**** COMPLETION OF A PRE-SCREEN MAY ACCELERATE THE UNDERWRITING PROCESS ****

Agent Name _____

Agent Phone Number _____

E-mail Address _____

Proposed Insured's Legal Name _____

Date of Birth/Age _____

Gender _____

State of Residence _____

PROPOSED COVERAGE

Purpose of Insurance: _____

Term Plan:

10

15

20

25

30

Permanent:

Guaranteed UL

Indexed UL

Whole Life

Riders:

Rate Class: _____

Face Amount: _____

Premium Mode: _____

Annual

Semi-Annual

Quarterly

Monthly

Riders:

Return of Premium

Waiver of Premium

Accidental Death Benefit

Child Rider Amount _____

Guarantee to Age: _____

1035 Exchange Amount: _____

Desired Monthly LTC Benefit: _____

Disability Insurance:

Benefit amount: _____

Benefit period: _____

Elimination period: _____

PREVIOUS APPLICATIONS/FINANCIAL INFORMATION

Have you ever had a life insurance application declined? If so, please provide details and dates: _____

Have you ever declared bankruptcy? If so, please provide details and dates: _____

NICOTINE AND ALCOHOL USE

Current Nicotine Use:

None

Cigarettes - packs per day: _____

Cigars - quantity per month: _____

Pipe

Dip/Chew

Nicotine Replacement (e.g. patch or gum)

Vape/E-cigarette

Other: _____

Alcohol Use:

How often do you consume alcohol?

___ Daily ___ Weekly ___ Monthly

___ Less than Monthly ___ Never

How many drinks per occasion? _____

Previous Tobacco Use (list each type of tobacco, quantity, and frequency used, and date of last use): _____

MEASUREMENTS

Height: ___ feet ___ inches Weight: _____ pounds Any change in weight more than 10lbs in the last 6 months: _____ lbs gained _____ lbs lost

Method of weight loss (e.g., diet exercise, medications, unintentional): _____

FAMILY HISTORY (FAMILY HISTORY IS A CONSIDERATION FOR EACH RATE CLASS):

To your knowledge, is there any family history (parent or siblings) of illness due to cardiovascular disease, cerebrovascular disease, diabetes, cancer, or dementia before age 65?

Yes

No

If yes, please provide full details of the illness including age at onset and age/cause of death if deceased. If the illness is cancer, please include the type of cancer.

Father: _____

Mother: _____

Siblings: _____

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BLOOD PRESSURE AND CHOLESTEROL

Latest BP reading: ____/____ Date: _____ Latest total cholesterol: _____ mg Date: _____

Latest total cholesterol/HDL ratio: _____

Have you ever taken or are you currently taking any medication for blood pressure?

- No
 Yes, name of medication: _____

Have you ever taken or are you currently taking any medication to lower cholesterol?

- No
 Yes, name of medication: _____

AVIATION/AVOCATION

In the past 5 years, have you or do you intend to participate in any of the activities listed?

- None
 Piloting an aircraft
 Mountain climbing
 Racing
 Skydiving
 Scuba diving
 Other (Please specify): _____

CITIZENSHIP/RESIDENCY/TRAVEL

US Citizen:

- Yes
 No

If no, provide type and expiration date of visa, green card status, and length of time in USA:

Any recent/planned travel outside the US? No Yes When (include duration)? _____ Where? _____ Purpose? _____

DRIVING/LEGAL HISTORY

Have you had any of the following motor-vehicle-related incidents in the past 10 years?

- Moving violation
 Reckless driving Provide dates, details: _____
 DWI or DUI Any speeding tickets in the past 3 years?: _____
 License suspension
 License revoked

Have you been convicted of a felony in the last 10 years? If yes, please provide details and dates: _____

MEDICAL HISTORY

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcohol use disorder/ at risk drinking | <input type="checkbox"/> Glucose intolerance/diabetes
(Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2; Hgb A1c _____) | <input type="checkbox"/> Marijuana/CBD use (<input type="checkbox"/> recreational <input type="checkbox"/> prescribed)
Amount/frequency of use: _____ |
| <input type="checkbox"/> Alzheimer's/dementia/cognitive impairment | <input type="checkbox"/> Heart murmur/valve disease | <input type="checkbox"/> Multiple sclerosis/seizures/other neurological disorder |
| <input type="checkbox"/> Asthma/COPD/other lung condition | <input type="checkbox"/> Hepatitis (type: _____) | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Illicit substance use | <input type="checkbox"/> Rheumatoid arthritis or other rheumatic/ autoimmune disorders |
| <input type="checkbox"/> Bone/joint/muscle/skin disorder | <input type="checkbox"/> Inflammatory bowel disease (e.g. Crohn's disease or ulcerative colitis)/other GI condition | <input type="checkbox"/> Sleep apnea or other sleep disorder
(<input type="checkbox"/> prior sleep study <input type="checkbox"/> uses CPAP) |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Irregular heartbeat/palpitations | <input type="checkbox"/> Stroke or other cerebrovascular disease |
| <input type="checkbox"/> Cirrhosis/fatty liver disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other conditions not listed: _____ |
| <input type="checkbox"/> Coronary artery or other heart disease | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Depression/anxiety/other psychiatric illness
(Please specify: _____) | | |

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List dates, diagnosis, details, treatments (including past surgeries/operations), plus names, addresses, and phone numbers of all physicians consulted :

List current/recent medications and supplements including name, dose, frequency of use, and start/end dates. Please include reason for medication if not specified above:

If any medical conditions are noted above, please complete the applicable illness-specific questionnaires to improve the accuracy of the pre-screen results.



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