



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:

Rate Class: _____

Face Amount: _____

Premium Mode: _____

- ☐ Annual
☐ Semi-Annual
☐ Quarterly
☐ Monthly

Term Plan:

- ☐ 10
☐ 15
☐ 20
☐ 25
☐ 30

Riders:

- ☐ Return of Premium
☐ Waiver of Premium
☐ Accidental Death Benefit
☐ Child Rider Amount _____

Permanent:

- ☐ Guaranteed UL
☐ Indexed UL
☐ Whole Life

Riders:

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: _____

CLIENT PRE-SCREEN QUESTIONNAIRE

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

☐ DWI or DUI

☐ License suspension

☐ License revoked

Provide dates, details: _____

Any speeding tickets in the past 3 years?: _____

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:

☐ Alcohol use disorder/ at risk drinking

☐ Alzheimer's/dementia/cognitive impairment

☐ Asthma/COPD/other lung condition

☐ Blood disorder

☐ Bone/joint/muscle/skin disorder

☐ Cancer (type: _____)

☐ Cirrhosis/fatty liver disease

☐ Coronary artery or other heart disease

☐ Depression/anxiety/other psychiatric illness
(Please specify: _____)

☐ Glucose intolerance/diabetes
(Type: ☐ 1 ☐ 2; Hgb A1c _____)

☐ Heart murmur/valve disease

☐ Hepatitis (type: _____)

☐ Illicit substance use

☐ Inflammatory bowel disease (e.g. Crohn's disease or ulcerative colitis)/other GI condition

☐ Irregular heartbeat/palpitations

☐ Kidney disease

☐ Lupus

☐ Marijuana/CBD use (☐ recreational ☐ prescribed)
Amount/frequency of use: _____

☐ Multiple sclerosis/seizures/other neurological disorder

☐ Peripheral vascular disease

☐ Rheumatoid arthritis or other rheumatic/autoimmune disorders

☐ Sleep apnea or other sleep disorder
(☐ prior sleep study ☐ uses CPAP)

☐ Stroke or other cerebrovascular disease

☐ Other conditions not listed: _____

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

CLIENT PRE-SCREEN QUESTIONNAIRE

List dates, diagnosis, details, treatments (including past surgeries/operations):

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:



Columbia • Atlanta • Charleston • Charlotte • Kansas City • Knoxville • Nashville • Raleigh • Richmond

Home Office : 1612 Marion St, Columbia, SC 29201

www.thecasongroup.com • 803.252.3033 • 800.951.3033