



CLIENT DISABILITY INSURANCE PRE-SCREEN

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

Name (First, Middle, Last)

Address

Date of Birth (Month/Day/Year)	Age	Gender	Total K-1 Income (Salary, Bonus, etc.)
Occupation (Please include job duties and percentage of time spent for each):			Existing In-force Disability Insurance:
Business owner? No Yes			Individual: _____ Taxable: <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of employees: _____			Group: _____ Taxable: <input type="checkbox"/> Yes <input type="checkbox"/> No
			Monthly Benefit Cap: _____

PROPOSED COVERAGE

Benefit amount: _____

Benefit period: _____

Elimination period: _____

Riders:

- Cost of Living Adjustment
- Own Occupation
- Residual Disability
- Catastrophic Disability
- Other: _____

NICOTINE 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: _____

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): _____

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"/> Lupus
<input type="checkbox"/> Alzheimer's/dementia/cognitive impairment	<input type="checkbox"/> Eye/vision problems	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Asthma/COPD/other lung disorder	<input type="checkbox"/> GERD or other GI condition (Please specify: _____)	<input type="checkbox"/> Marijuana/CBD use (<input type="checkbox"/> recreational <input type="checkbox"/> prescribed) Amount/frequency of use: _____
<input type="checkbox"/> Back or other chronic pain or musculoskeletal/joint problems (Please specify: _____)	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Multiple sclerosis/seizures/other neurological disorder
<input type="checkbox"/> Barrett's esophagus/other GI condition	<input type="checkbox"/> Heart murmur/valve disease	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Cancer (type: _____)	<input type="checkbox"/> Hepatitis (type: _____)	<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Cirrhosis/fatty liver disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatoid arthritis or other rheumatic/autoimmune disorders
<input type="checkbox"/> Coronary artery or other heart disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sleep apnea or other sleep disorder (<input type="checkbox"/> Prior sleep study <input type="checkbox"/> Uses CPAP)
<input type="checkbox"/> Depression/anxiety/ADHD or other psychiatric illness (Please specify: _____)	<input type="checkbox"/> Illicit substance use	<input type="checkbox"/> Stroke or other cerebrovascular disease
<input type="checkbox"/> Disorders of the genitourinary/reproductive systems	<input type="checkbox"/> Inflammatory bowel disease (e.g. Crohn's disease or ulcerative colitis)	<input type="checkbox"/> Any other conditions not listed above: _____
	<input type="checkbox"/> Irregular heartbeat/palpitations	

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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. 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.

AVIATION/AVOCATION

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

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Skydiving |
| <input type="checkbox"/> Flying | <input type="checkbox"/> Scuba diving |
| <input type="checkbox"/> Mountain climbing | <input type="checkbox"/> Other (Please specify): |
| <input type="checkbox"/> Racing | _____ |

AGENT INFORMATION

Agent Name

Agent Phone Number

E-mail Address



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