THE CASON GROUP

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

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 Units: _____

Permanent:

- ☐ Guaranteed UL
- ☐ Indexed UL
- ☐ Whole Life

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 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): _____

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: _____

** All personal information protected by HIPAA regulations **

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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
☐ Flying
☐ 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. Chrohn'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: _____ _____

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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.