



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: _____

Term Plan:

10

15

20

25

30

Permanent:

Guaranteed UL

Indexed UL

Whole Life

Rate Class: _____

Face Amount: _____

Premium Mode: _____

Annual

Semi-Annual

Quarterly

Monthly

Riders:

Return of Premium

Waiver of Premium

Accidental Death Benefit

Child Rider Units: _____

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

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: _____

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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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