



General Medical Questionnaire

Agent Name: _____ **Phone:** _____

Proposed Insured Name: _____ **Sex:** Male Female **DOB:** _____

Face Amount Requested: \$ _____ **Maximum Annual Premium:** \$ _____

Plan Type: UL WL Term Survivorship

Tobacco Use

Do you currently smoke cigarettes? Yes No

If No, did you ever smoke? Never Quit (Date): _____

Do you currently use any other tobacco or nicotine products? (e.g., nicotine patch, cigars, pipe, snuff, gum) Yes No If Yes, provide details: _____

When did you last use any form of tobacco? MM/YY: _____ Type used last: _____

Medical History

Height: _____ Current Weight: _____

Has the proposed insured experienced a change in weight greater than 10 pounds in the past 12 months? Yes No

If yes, please specify pounds lost or gained and reason: _____

Has the proposed insured ever been diagnosed or treated by a licensed medical professional for any of the following conditions? Please check all that apply.

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer/Tumor/Polyp | <input type="checkbox"/> Seizures | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Sleep Apnea |

If yes, provide details:

Other than what is indicated above, has the proposed insured ever been diagnosed by a licensed medical professional with any disease or disorder involving any of the following?

If yes, please check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Arteries/Veins | <input type="checkbox"/> Lung/ Respiratory System |
| <input type="checkbox"/> Lymph Nodes | <input type="checkbox"/> Liver/Pancreas | <input type="checkbox"/> Thyroid/Other Glands |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Immune System | <input type="checkbox"/> Gastrointestinal/ Digestive System |
| <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Blood | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> Brain/Nervous System |
| <input type="checkbox"/> Muscles/Bones/Joints | <input type="checkbox"/> Prostate | <input type="checkbox"/> Reproductive Organs |
| <input type="checkbox"/> Emotional/Psychological Disorder | | |

If yes, provide details:

Other than what has been indicated previously, within the past five years has the proposed insured been diagnosed by any physician, practitioner, or healthcare facility as having had any illness, injury, surgery, physical examination, consultation, or medical test (e.g., laboratory tests, EKG, etc.), or been a patient in a hospital or other medical facility?

Is the proposed insured currently receiving treatment from a licensed medical professional or taking any prescription or non-prescription medications or supplements?

Does the proposed insured have any surgeries, medical tests, treatments, or appointments with a healthcare professional scheduled within the next six months?

Has the proposed insured ever tested positive for exposure to HIV, or been diagnosed with AIDS, ARC, or any other condition resulting from HIV infection?

Has the proposed insured ever used cocaine, heroin, barbiturates, amphetamines, hallucinogens, or any other controlled substances, except as prescribed by a healthcare professional?

Has the proposed insured ever sought, been advised to seek, or received counseling or treatment for alcohol or drug use from a licensed medical professional or support group?

Has the proposed insured ever been arrested for driving under the influence (DUI) or driving while intoxicated (DWI)?

To the best of your knowledge and belief, has a parent or sibling ever had heart disease, coronary artery disease, vascular disease, stroke/cerebrovascular disease, diabetes, cancer, or kidney disease? Yes No If yes, please provide details below.

Relationship to Proposed Insured	Ages if Living	Ages at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			