General Medical Questionnaire

Advanced Insurance Marketing Group • Pre-Underwriting Health Detail

INSURED & POLICY BASICS

Please complete every question as accurately as possible. Thorough answers allow us to return a fast, accurate pre-underwriting read.

AGENT INFORMATION

AGENT NAME

PHONE

PROPOSED INSURED

FULL NAME

SEX

☐ Male ☐ Female

DATE OF BIRTH

REQUESTED COVERAGE

FACE AMOUNT REQUESTED ($)

MAXIMUM ANNUAL PREMIUM ($)

PLAN TYPE — SELECT ONE

☐ 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:

MOST RECENT USE

LAST USED (MM/YY)

TYPE USED LAST

WEIGHT & GENERAL HEALTH

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 — pounds lost or gained and reason:

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

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Asthma/Bronchitis
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Cancer/Tumor/Polyp
- ☐ Seizures
- ☐ Arthritis
- ☐ Colitis
- ☐ Alzheimer's Disease
- ☐ Multiple Sclerosis
- ☐ Memory Loss
- ☐ Cirrhosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Paralysis
- ☐ Sleep Apnea

If yes — provide details:

BODY SYSTEMS HISTORY

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? Select all that apply.

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

If yes — provide details:

RECENT CARE & FOLLOW-UP

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?

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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?

SUBSTANCE USE & LEGAL HISTORY

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)?

FAMILY HISTORY

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	AGES IF LIVING	AGES AT DEATH	STATE OF HEALTH / CAUSE OF DEATH
Father			
Mother			
Sibling			
Sibling			
Sibling			