HEALTH QUALIFIER QUESTIONS

AIM GROUP • ADVANCED INSURANCE MARKETING GROUP

626-714-1444 • 13181 N Crossroads Pkwy, City of Industry, CA 91746 • workwithAIM.com

CLIENT INFORMATION

CLIENT NAME

DATE OF BIRTH

HEIGHT

WEIGHT

WEIGHT LOSS IN PAST YEAR (LBS)

LIFESTYLE & MEDICATIONS

Have you used any tobacco in any form within the past 10 years? ☐ Yes ☐ No

If yes, indicate type used and date last used:

Have you used cannabis in any form within the past 12 months? ☐ Yes ☐ No

If yes, indicate type used and how often:

Are you currently taking any drugs (Prescription and Over the Counter (OTC))? ☐ Yes ☐ No

If yes, please indicate medication name, reason and year prescribed:

Medication Name	Reason Taken	Year Prescribed

CITIZENSHIP, DRIVING & TRAVEL

Are you a US Citizen? ☐ Yes ☐ No If no, are you a permanent resident in the US? ☐ Yes ☐ No

Do you have an ITIN number? ☐ Yes ☐ No

Any DUI, DWI or reckless driving convictions? ☐ Yes ☐ No *If yes, dates:*

Any intended travel outside of the US? ☐ Yes ☐ No *Location & duration:*

FAMILY HISTORY

Any family history of cancer or cardiovascular disease prior to age 60 of parents or siblings:

Family Member	Gender	Alive / Deceased	Cause of Death	Age at Death

This information will be used for preliminary non-binding assessment only. It does not represent a contract or committal to a mortality risk associated with AIM Group or any life insurance carrier.

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MEDICAL HISTORY

In the past 25 years, have you had, been told you have, and/or been treated for:

1. Dizziness, headaches, seizures, convulsions, stroke, memory loss or any disease of the brain or nervous system?	☐ Yes	☐ No
2. Depression, anxiety or any psychological or emotional condition or disorder?	☐ Yes	☐ No
3. Shortness of breath, asthma, emphysema, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder?	☐ Yes	☐ No
4. Hepatitis, chest pain, irregular heartbeat, murmur, heart attack or any disorder of the heart or blood vessels?	☐ Yes	☐ No
5. Diabetes (sugar), albumin, sexually transmitted disease (STD), or any disorder of the kidney, bladder, prostate or reproductive organs, thyroid, or endocrine disorder?	☐ Yes	☐ No
6. Cancer, tumor, polyp, or disorder of the lymph glands or breasts?	☐ Yes	☐ No
7. Anemia or any disorder of the blood?	☐ Yes	☐ No
8. Rheumatoid arthritis or any disorder of the muscles, bones, joints or spine?	☐ Yes	☐ No
9. Persistent or unexplained fatigue, fever or illness?	☐ Yes	☐ No
10. Sought, received, and/or been recommended treatment for use of alcohol or drugs (marijuana, cocaine, heroin, amphetamine, hallucinogens, tranquilizers, sedatives, narcotics, or legally prescribed drugs)?	☐ Yes	☐ No
11. In the past 10 years, have you ever used any of the above drugs?	☐ Yes	☐ No
12. Has a member of the medical profession ever diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes	☐ No
13. Have you ever been declined, postponed or rated on ANY prior insurance consideration submissions?	☐ Yes	☐ No

EXPLANATIONS FOR ALL “YES” ANSWERS

Please provide explanations, dates diagnosed and treatment completion dates to all yes answers.
Provide as much detail as possible for a more accurate pre-assessment.

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