UNDERWRITING QUESTIONNAIRE

Agent Name: _____ Phone: _____
Agent Email: _____ State of Issue/Delivery: _____
Proposed Insured's Name: _____ ☐M ☐F Date of Birth: _____
Height: ____ft. ____in. Weight:_____lbs. Current Cigarette Smoker? ☐ No ☐ Yes
Ever a cigarette smoker? ☐ No ☐ Yes Date last used: _____
Any other tobacco use? (cigar, pipe, snuff/chew, patch, gum, e-cigarette) ☐ No ☐ Yes
If yes, provide details: _____
Last date any form of tobacco used?_____Face Amt:$_____ ☐ Term ☐ Perm ☐ Surv.

HEART DISEASE – AORTIC REGURGITATION/STENOSIS

Date of diagnosis: _____

Have you been diagnosed or have you experienced any of the following:

☐ Light headedness ☐ Breathlessness ☐ Blackouts ☐ Aortic Stenosis ☐ Coughing up blood
☐ Rheumatoid arthritis ☐ Syphilis ☐ Ankylosig spondylitis ☐ Marfan's syndrome ☐ Edema/swelling
☐ Elevated Cholesterol – most recent known levels Date: _____ Chol _____ LDL _____ HDL _____Triglycerides _____
☐ High blood pressure – most recent reading(s):_____
☐ Diabetes – age of onset: _____ Recent A1C test result:_____ (*Also, please ask us for our diabetes questionnaire*)
☐ Family history of heart disease. Please list who and at what age(s) diagnosed: _____
☐ Other (Describe): _____

Provide dates if any of the following tests or procedures (a) have been done or (b) recommended be done:

☐ Resting EKG: _____ ☐ Stress EKG: _____
☐ Thallium Stress EKG: _____ ☐ Echocardiogram: _____
☐ Coronary Catheterization _____ ☐ Stress Echocardiogram: _____
☐ Valve replacement surgery – which valves?: _____
☐ Angioplasty – what specific type? (e.g. balloon): _____
☐ Bypass surgery: _____ Number of vessels involved: _____
☐ Other (Describe): _____

Please provide information on medications currently taking, including preventative aspirin:

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

Please describe any specific diets (e.g. vegetarian) or dietary supplements (vitamins, folic acid, etc.) of the proposed insured:

_____

Please describe the proposed insured's regular exercise or sporting activity:

_____

Please provide additional details about the proposed insured's medical history:

Please use the fillable fields to complete the form, then save and email to our underwriting team at underwriting@dbs-lifemark.com.
You may also print and fax completed form to 952.697.5003. Questions? Call the Underwriting Team at x2312.