		UNDERWRITING Q	UESTIONNA	MRE			
	Agent Name:				Phone:		
4:0	Agent Email:				State of Issue/Delivery:		
	Proposed Insure	d's Name:		М	F Date o	f Birth:	
8		in. Weight:			igarette Smok	er? No	Yes
		smoker? No			_		
		co use? (cigar, pipe, s					Yes
our Underwriting Resource	If yes, provide de			-	last use (othe		'
Underwriting Res	Face Amt:			Other(provide de	, —		Surv.
		BREAST CA		VI	,		
Date of diagnosis:				homo radiatio	n etc.):		
		Date of last treatment	. (Surgery, c	nemo, radiatio	iii, etc.j		
*If possible, please include of							
Exact name of the type of br	east cancer:	Grade I Grad	_	Mucoid, Medu	ıllary, Tubular	, Papillary	
Primary Tumor ("T")		LCIS, in situ T1	☐ T1a	T1b	T1cT	2 T3 -	T4
Lymph Node ("N")	■N0 ■N1-3	N4-9 N9 or mo	re				
Metastasis/spread ("M")	Пмо Пм1						
•		() □c.(1)			. —		
How was the cancer treated				limited excision) Lumpe	ctomy (wide excisi	ion)
Modified Radical Mastect			l Mastecton				
Radiation Therapy - Date	(s):	Cnemo	therapy - D	ate(s):			
Were Estrogen Receptors Po	sitive (ER, PR, HE	R2/NEU/ErbB2) 🔲 N	No 🗌 Ye	s (Please indi	cate):		_
Has the proposed insured ta	•	I therapy? (i.e. Tamo) etails:	kifen, Femai	ra, Amatase, A	nastrolzole, A	rmidex, etc.)	
Has there been any evidence of recurrence? No Yes If Yes, please provide details:							
Does the proposed insured t				t this time?	☐ No	Yes	
in yes, preuse provide name o	31 medication and	i dosage.					
Has the proposed insured ha		ting? (BRCA1 or BRCA	(2)	No Ye	es		
If yes, please provide details							
Door the proposed incured h	any other my	odical conditions?		No. D.V	0.5		
Does the proposed insured h		edical conditions?		No Y	es		
If yes, please provide details							
Please provide additional de	tails about the pr	oposed insured's med	dical history	:			
	•		•				

Other options: Fax completed form to 952.697.5003, or submit your saved PDF to underwriting@dbs-lifemark.com. Questions? Call your Underwriting Team at x2312.