

## 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.

### CANCER - GENERAL

You have indicated that your client has had cancer. This form is meant to determine what type of cancer so we may evaluate the risk.

Please list type of cancer: \_\_\_\_\_ Date(s) of diagnosis \_\_\_\_\_

Indicate how the cancer was treated: ☐ Radiation therapy ☐ Total Excision/Removal  
☐ Chemotherapy

*\*If possible, please include a copy of the pathology report.*

Please list the date treatment completed: \_\_\_\_\_

Please list the date and results of last follow-up imaging studies and/or lab testing: \_\_\_\_\_

What stage was the cancer?

☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

Were lymph nodes involved? ☐ No ☐ Yes

Has there been any evidence of recurrence? ☐ No ☐ Yes

If Yes, please provide details:

Does the proposed insured take any medications (prescription or otherwise) at this time? ☐ No ☐ Yes

If yes, please provide name of medication and dosage:

Does the proposed insured have any other medical conditions? ☐ No ☐ Yes

If yes, please provide details:

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

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

