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.

CHRONIC PAIN

Date of onset: _____ Medical condition/impairment for the source of the chronic pain: _____

If due to injury, describe how the proposed insured was injured and symptoms experienced as a result:

_____

Does the proposed take prescription pain medication? ☐ No ☐ Yes Long-term or temporary? ☐ Long-term ☐ Temporary
If yes, please provide name of medication(s), dosage(s), frequency taken and plan to be off medication:

_____

Has the proposed insured ever used more medication than what was prescribed? ☐ No ☐ Yes
If yes, please provide details: _____

Is the proposed insured prescribed medical marijuana? ☐ No ☐ Yes
If yes, please provide prescription details as to how much, how often used, and method (smoked, ingested, drops, etc.)

_____

How often does the proposed see his/her doctor or pain management specialist? _____

Is the proposed significantly impaired in normal day-to-day activities? ☐ No ☐ Yes
If yes, please provide limitations: _____

On a pain scale of 1-10 how does the client describe his/her level of pain? (1 = very mild; 10 = severe)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does the proposed attend support groups and/or chronic pain rehabilitation such as physical therapy? ☐ No ☐ Yes
If yes, provide details: _____

Is the proposed currently working? ■ No ■ Yes Proposed insured's occupation: _____

Is the proposed on disability? ■ No ■ Yes If yes, date disability began: _____

Is the disability going to be: ☐ Permanent ☐ Temporary If temporary, approximate duration of disability: _____

Has the proposed ever had a history of anxiety, depression, or other mental health condition? ☐ No ☐ Yes
If yes, provide full details: _____

Has the proposed insured ever had a history of drug or alcohol abuse? ☐ No ☐ Yes
If yes, provide details: _____

Does the proposed currently drink alcohol? ■ No ■ Yes If yes, amount per sitting and frequency: _____

Does the client use any recreational drugs? ■ No ■ Yes If yes, advise type and frequency: _____

Please list medications, including names, quantity taken, and frequency other than those already detailed above:

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.
You may also print and fax completed form to 952.697.5003. Questions? Call the Underwriting Team at x2312.