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.

COLITIS & CROHN'S DISEASE

Date of first diagnosis: _____ Date of most recent episode: _____ Total Number of episodes: _____
Number of episodes past six months:_____ Longest duration:_____ (days, weeks, months)
Number of episodes past five years: _____ Longest duration:_____ (days, weeks, months)

What condition(s) have been diagnosed?

☐ Irritable Bowel Syndrome ☐ Frequent colon spasms ☐ Frequent diarrhea ☐ Ischemic Colitis
☐ Mucous Colitis ☐ Spastic Colitis ☐ Catarrhal Colitis ☐ Ulcerative Proctitis
☐ Chronic Proctitis (rectum) ☐ Chronic Ulcerative Colitis ☐ Crohn's Disease ☐ Ulcerative Proctosigmoiditis
☐ Other (Describe): _____

Is the diagnosis considered:
☐ Mild ☐ Moderate ☐ Severe

Is the proposed insured taking any medication? ☐ Yes ☐ No

If yes, please provide details:

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

Date of last Colonoscopy_____ Result: _____

Has the proposed insured ever been hospitalized for the condition? ☐ Yes ☐ No
If Yes, Please provide details: _____

Has surgery been recommended? ☐ Yes ☐ No
If Yes, Please provide details: _____

Has surgery been done? ☐ Yes ☐ No
If yes, please list dates and type of surgery(ies): _____

Has there been any significant effect on day-to-day functionality or lost time from work? ☐ Yes ☐ No
If Yes, Please provide details: _____

Has the proposed insured ever been disabled because of the condition? ☐ Yes ☐ No
If yes, please provide date(s) and details: _____

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.