

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.

LUNG DISEASE / CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Date of diagnosis: _____

Type of lung disease diagnosed:

- ☐ Asthma ☐ Chronic Bronchitis ☐ COPD (Please indicate severity below):
☐ Emphysema ☐ Restrictive lung disease ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme
☐ Other (Describe): _____

Has the proposed insured ever been hospitalized for this condition? ☐ Yes ☐ No If yes, provide date(s): _____

Has a pulmonary function test(breathing test) ever been done? ☐ Yes ☐ No If yes, provide details below: _____

Has a chest x-ray been done? ☐ Yes ☐ No If yes, provide date: _____ Results: _____

Has an ECG been done recently? ☐ Yes ☐ No If yes, provide date: _____ Results: _____

Is the client using oxygen? ☐ Yes ☐ No If yes, provide date(s): _____

Please provide information on medications currently taking:

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

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.

