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.

CAROTID ARTERY STENOSIS

Is the proposed insured diagnosed with: ☐ Single ☐ Bilateral carotid stenosis Date of last Carotid Ultrasound: _____
If known, percentage on right side: _____% percentage on left side: _____%
Is there a history of Carotid Bruit (noise heard on examination due to turbulent blood flow in the carotid artery)? ☐ Yes ☐ No
Has the proposed insured had an Endarterectomy (removal of carotid plaque) or stenting for carotid stenosis? ☐ Yes ☐ No
If yes, indicate method of treatment: _____ Date: _____
Does the proposed insured take Anticoagulants/blood thinning medication (e.g. Aspirin, Coumadin) ☐ Yes ☐ No
If yes, provide details in the medication section below.

Does the proposed insured have a history of any of the following:

High blood pressure ☐ Yes ☐ No If yes, provide a recent reading (if known): _____
High Cholesterol ☐ Yes ☐ No Total Cholesterol: _____ HDL: _____ Triglycerides: _____
Diabetes ☐ Yes ☐ No If yes, ☐ Type 1 ☐ Type II Date diagnosed: _____ Recent A2C level
TIA (transient ischemic attack) ☐ Yes ☐ No If yes, provide date(s):_____
Stroke ☐ Yes ☐ No If yes, provide date(s):_____
Please provide details of any residual impairment caused by the stroke (e.g. paralysis, weakness, other) in details section below.
Blood Clot ☐ Yes ☐ No If yes, provide date(s) and details:_____
Peripheral Vascular Disease ☐ Yes ☐ No If yes, provide date(s) & any treatment (e.g. stent, bypass surgery, other):
_____
Coronary Artery Disease ☐ Yes ☐ No If yes, provide date(s) & any treatment (e.g. stent, bypass surgery, other):
_____
Heart Attack ☐ Yes ☐ No If yes, provide date(s) & any treatment (e.g. stent, bypass surgery, other):
_____
Stress test ☐ Yes ☐ No ☐ Never Performed If yes, provide date(s) & results: _____

Is there a family history of cardiac or vascular disease? ☐ Yes ☐ No If yes, provide details of whom, what condition, their age of onset, age at death (if applicable): _____

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.