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.

DIABETES

Date of diagnosis:_____ Age at Onset: _____

Type of Diabetes: ☐ Type I (Juvenile) ☐ Type II (Adult)

Most current A1C test reading: _____ Date: _____
It is very important to have these numbers for any useful pre-underwriting premium estimate.

How often does the proposed insured visit their physician for a diabetic checkup?
☐ Monthly ☐ Every 3 months ☐ Every 6 months
☐ Annually ☐ Less than annually

The proposed insured controls their diabetes by: *(Check all that apply.)*
The accuracy of the information below is important in assessing your client's potential rating.
☐ Diet ☐ Regular Exercise (Indicate type and frequency):
☐ Oral Medication (indicate medication, dosage frequency) _____
☐ Insulin: _____ (units per day) ☐ Insulin Pump

Has the proposed insured's treatment been changed in the last 2 years? ☐ No ☐ Yes If Yes, please provide details:

Does the proposed insured take any other medications (prescription or otherwise) at this time? ☐ No ☐ Yes
If yes, please provide name of medication and dosage:

Other Recent Readings
Blood Sugar reading: _____ Microalbumin level: _____ Blood Pressure: _____
Triglycerides: _____ LDL (bad cholesterol): _____ HDL (good cholesterol): _____

Has the proposed insured experienced any of the following? If yes, please provide details below.
☐ Weight Problems ☐ High blood Pressure ☐ Chest Pain ☐ Insulin shock
☐ Coronary Artery Disease ☐ Elevated lipids ☐ Diabetic Coma ☐ Abnormal ECG
☐ Neuropathy (Nerve Pain) ☐ Retinopathy (Eye) ☐ Kidney Disease ☐ Alcohol/Drug abuse
☐ Protein in the Urine ☐ Glycosuria (Sugar in Urine) ☐ Other
Explain:

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.