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: _____ Date of last use (other form):_____

Face Amt:_____ Riders Desired: ☐LTC/CI ☐Other(provide details below) ☐Term ☐Perm ☐Surv.

DRUG USE

Are you now using or have you ever used any of the following, other than for treatment of a medical condition under proper medical supervision? (Please check all that apply.)

a) Amphetamines, i.e. "Ecstasy," "Ice," MDMA, "Speed," "Uppers," etc.	☐ Yes	☐ No
b) Barbiturates, i.e. "Downers," etc.	☐ Yes	☐ No
c) Cannabis, i.e. "Hashish," Marijuana, "Pot," "Weed," etc.	☐ Yes	☐ No
d) Cocaine, i.e. "Coke," "Crack," "Snow," etc.	☐ Yes	☐ No
e) Hallucinogens, i.e. "Acid," "Angel Dust," "Haze," LSD, "Microdots," etc.	☐ Yes	☐ No
f) Herbs, i.e. catnip, poppy, kava kava, Lobelia, etc.	☐ Yes	☐ No
g) Opiates, i.e. Codeine, Heroin, Methadone, Morphine, Opium, "Smack," etc.	☐ Yes	☐ No
h) Sedatives, i.e. Diazepam, "Downers," Nitrazepam "Tranks," etc.	☐ Yes	☐ No
i) Solvents, i.e. Aerosols, glue, etc.	☐ Yes	☐ No
j) Alcohol	☐ Yes	☐ No
k) Other	☐ Yes	☐ No

If YES to any of the above, please provide full details, including name of drug and dates when usage commenced and ceased.

Have you ever sought medical treatment due to drug usage or detoxification? ☐ No ☐ Yes If yes, provide details/dates:

Have you suffered from any impairments associated with drug usage? (i.e. hepatitis B, HIV infection, mental illness, etc.)
☐ No ☐ Yes If yes, please provide details:

Are you now drug-free? ☐ No ☐ Yes If YES, please state when usage ceased: _____

Have you had any legal trouble because of drug use? ☐ No ☐ Yes If yes, please provide details:

Are you currently attending meetings of N.A. or similar recovery group? ☐ No ☐ Yes
If YES, please provide dates 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.