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.

EPILEPSY / SEIZURE DISORDER

Date of Diagnosis: _____ Date of last seizure: _____

What type of Epilepsy or Seizure has been diagnosed?

☐ Generalized Epilepsy: Choose as many as applicable below.

- ☐ Absence (Petite Mal) Seizures
- ☐ Myoclonic Seizures
- ☐ Tonic Seizures
- ☐ Nocturnal Seizures
- ☐ Tonic Clonic (Grand Mal) Seizures
- ☐ Febrile (associated with fever) Seizures
- ☐ Atonic Seizures
- ☐ Reflex Seizures (television Epilepsy)

☐ Partial (Focal) Epilepsy: Choose as many as applicable below.

- ☐ Simple Partial Seizures (Jacksonian)
- ☐ Partial Seizures
- ☐ Complex Partial Seizures (includes temporal lobe)
- ☐ Other (Please describe): _____

What type of symptoms accompany the epileptic episodes? (Please answer only one.)
☐ Unconsciousness ☐ "Clouded Consciousness" ☐ Uncontrolled twitching movements ☐ Deep sleep

How frequent are the epileptic episodes? (Please answer only one.)

- ☐ One episode only
- ☐ Several episodes but clustered in a very short period of time and none since that time
- ☐ 6 or less per year
- ☐ 7-12 per year
- ☐ 13 or more per year: _____ Per month _____ Per week _____ Per day

What type of medications are used to control the condition? Please provide name of medication and dosage:

Has any surgical procedure been recommended/done to treat the Epileptic condition? ☐ No ☐ Yes
If yes, please list date of surgery and details:_____
_____

Personality or mentality changes?	☐ No	☐ Yes	If yes, please describe: _____
History of alcohol misuse?	☐ No	☐ Yes	If yes, please describe: _____
Compliant with recommended treatment?	☐ No	☐ Yes	If yes, please describe: _____
Does the proposed insured drive a car?	☐ No	☐ Yes	If yes, please describe: _____
Is there any history of motor vehicle accidents?	☐ No	☐ Yes	If yes, please describe: _____
Does the proposed insured engage in any hazardous activities including aviation or scuba diving?	☐ No	☐ Yes	If yes, please describe: _____

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.