

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.

GASTRIC/BARIATRIC SURGERY OR BYPASS

Date of procedure: _____ Type of procedure (e.g. gastric bypass, banding, etc.): _____

Weight prior to procedure: _____ lbs. Current weight: _____ lbs. Has weight loss been stable? ☐ Yes ☐ No

Select and provide details if any of the complications have occurred:

- ☐ Hemorrhage: _____
- ☐ Obstruction: _____
- ☐ Perforation: _____
- ☐ Leaks: _____
- ☐ Abnormal liver function studies: _____
- ☐ Hypoglycemia: _____
- ☐ Anemia: _____
- ☐ Nutritional deficiencies: _____
- ☐ Vomiting or nausea: _____
- ☐ Change in bowel habits/diarrhea due to dietary modifications: _____
- ☐ Failure to lose weight: _____
- ☐ Problems retaining weight: _____
- ☐ Dumping syndrome: _____

Any history, past or present, of associated chronic disease including diabetes, hypertension, hyperlipidemia, obstructive sleep apnea, or cardiovascular disease? ☐ Yes ☐ No

If yes, please provide details below:

Please provide additional details about the proposed insured's medical history, including any factors that may be relevant to assessment of the insurability of this individual:

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.

