

# 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.

## HEART DISEASE/HEART ATTACK/BYPASS/ANGIOPLASTY/STENT

Date(s) or frequency of episode(s) of symptoms relating to the bypass surgery (CABG)

- Angina pectoris: \_\_\_\_\_
- Coronary thrombosis/occlusion: \_\_\_\_\_
- Coronary insufficiency: \_\_\_\_\_
- Myocardial infraction (heart attack): \_\_\_\_\_

Provide dates if any of the following tests or revascularization procedures have been done:

- |   |  |
|---|--|
| <input type="checkbox"/> If bypass, was the mammary artery used? <input type="checkbox"/> Yes <input type="checkbox"/> No | How many vessels were bypassed? _____ Date of surgery: _____     |
| <input type="checkbox"/> Resting EKG: _____   | <input type="checkbox"/> Stress EKG: _____                       |
| <input type="checkbox"/> Thallium Stress EKG: _____   | <input type="checkbox"/> Echocardiogram: _____                   |
| <input type="checkbox"/> Coronary Catheterization: _____  | <input type="checkbox"/> Coronary Angioplasty: _____             |
| <input type="checkbox"/> Percutaneous transluminal angioplasty (PTCA) : _____   | <input type="checkbox"/> Directional Coronary Atherectomy: _____ |
| <input type="checkbox"/> Rotational Atherectomy: _____  | <input type="checkbox"/> Coronary Artery Stents: _____           |
| <input type="checkbox"/> Laser Treatment: _____   | <input type="checkbox"/> Perfusion Balloon Catheter: _____       |
| <input type="checkbox"/> Other (Describe): _____  |  |

Please check if the proposed insured has been diagnosed with any of the following conditions:

- ☐ Elevated Cholesterol – most recent known level(s): \_\_\_\_\_
- ☐ High Blood Pressure – most recent reading: \_\_\_\_\_
- ☐ Diabetes – age of onset: \_\_\_\_\_ Recent A1C test result: \_\_\_\_\_ (Also please ask for our diabetes questionnaire)
- ☐ Family history of heart disease (Please indicate who and at what age(s) diagnosed): \_\_\_\_\_
- ☐ Other (Describe): \_\_\_\_\_

Please provide information on medications currently taking, including preventative aspirin:

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@dbb-lifemark.com](mailto:underwriting@dbb-lifemark.com).  
 You may also print and fax completed form to 952.697.5003. Questions? Call the Underwriting Team at x2312.

