

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.

LEUKEMIA

Date of diagnosis: _____ Date of last treatment: _____

Type of Leukemia: (check one)

- ☐ Acute Lymphoid (ALL) ☐ Chronic Lymphoid (CLL) ☐ Hairy Cell
☐ Acute Myeloid (AML) ☐ Chronic Myeloid (CML)

****If possible, please include a copy of the pathology report.***

Indicate stage (Rai) of cancer: ☐ 0 ☐ I ☐ II ☐ III ☐ IV

Bone Marrow Transplant? ☐ Yes ☐ No Type: ☐ Allogenic (donor) ☐ Autologins (self)

Has the spleen been removed as part of the treatment procedure? ☐ No ☐ Yes If yes, date: _____

Please indicate any other types of treatment including dates:

Has there been any evidence of recurrence, relapse, or related illness? ☐ No ☐ Yes

If yes, please provide details:

Most current blood count (CBC) readings:

Date _____ White blood cells _____ Hemoglobin _____ Platelets _____

How frequently does the proposed insured visit his/her health care provider for check-ups including blood counts?

Does the proposed insured take any medications (prescription or otherwise) at this time? ☐ No ☐ Yes

If yes, please provide name of medication and dosage:

Please provide additional details about the proposed insured's medical condition:

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.

