

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 – MITRAL VALVE DISEASE – PROLAPSE – REGURGITATION - STENOSIS

Date of diagnosis: _____

Have you been diagnosed or have you experienced any of the following:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Light headedness | <input type="checkbox"/> Breathlessness | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Mitral Regurgitation | <input type="checkbox"/> Mitral Stenosis |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Ankylosis spondylitis | <input type="checkbox"/> Barlow's syndrome | <input type="checkbox"/> Edema/swelling |
| <input type="checkbox"/> Elevated Cholesterol – most recent known levels Date: _____ Chol _____ LDL _____ HDL _____ Triglycerides _____ | | | | |
| <input type="checkbox"/> High blood pressure – most recent reading(s): _____ | | | | |
| <input type="checkbox"/> Diabetes – age of onset: _____ Recent A1C test result: _____ (Also, please ask us for our diabetes questionnaire) | | | | |
| <input type="checkbox"/> Family history of heart disease. Please list who and at what age(s) diagnosed: _____ | | | | |
| <input type="checkbox"/> Other (Describe): _____ | | | | |

Provide dates if any of the following tests or procedures (a) have been done or (b) recommended be done:

- | | |
|--|---|
| <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"/> Stress Echocardiogram: _____ |
| <input type="checkbox"/> Valve replacement surgery – which valves?: _____ | |
| <input type="checkbox"/> Angioplasty – what specific type? (e.g. balloon): _____ | |
| <input type="checkbox"/> Bypass surgery: _____ | Number of vessels involved: _____ |
| <input type="checkbox"/> 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 describe any specific diets (e.g. vegetarian) or dietary supplements (vitamins, folic acid, etc.) of the proposed insured:

Please describe the proposed insured's regular exercise or sporting activity:

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.

