

Build Questionnaire



Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	Gender	Height	Weight	Marital Status
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		Type Used
Type of Coverage	Term	UL	Survivor	Amount \$

Essential Information				
1	Has the client gained or lost weight in the past 12 months	<input type="checkbox"/> Yes	Increase (pounds)	
		<input type="checkbox"/> No	Decrease (pounds)	
2	Please check if client has had any of the following: (if any of the listed are checked, please complete specific related questionnaire)	Coronary Artery Disease		High Blood Pressure
		Diabetes		Elevated Cholesterol or Triglycerides (lipid levels)
3	Has client ever had any weight reductions surgery	<input type="checkbox"/> Yes	If yes please details:	
		<input type="checkbox"/> No		
4	List Current Medications (Accurate name, dosage and reason)			
5	Has a stress electrocardiogram (treadmill test) been completed within the past year	<input type="checkbox"/> Yes	<input type="checkbox"/> Abnormal	<i>date</i>
		<input type="checkbox"/> No	<input type="checkbox"/> Normal	<i>date</i>
6	Are there any other health issues?	<i>details</i>		