Informal Underwriting (Confidential) Inquiry

11/13

Applicant Full Name			Social Security Number	Birth Date
Gender ○ Male ○ Female	Height	Weight	Place of Birth (State/Country)	
Current Residential Address (Street, City, State, Zip)				
Occupation (Title, Type of Business			Driver's License Number	State
Used Tobacco in past 5 years? ○ Yes ○ No	Tobacco Type Used? ○ Chew ○ Cigarettes ○ Cigars ○ Pipe			Last Date Used

Expectations Premium $	Plan ○ Term _____ # of yrs ○ Permanent ○ Survivorship		Rating Needed?
Insurance In Force For Replacement? ○ Yes ○ No	Ever Been Declined? ○ Yes ○ No Ever Been Rated? ○ Yes ○ No	If yes, Details	
Coverage ○ Current ○ Pending Date ○ Current ○ Pending Date ○ Current ○ Pending Date	$ Amount $ Amount $ Amount	Company Name Company Name Company Name	

Current Primary Physician	Physician Address	Physician Phone
Current Medications & Prescriptions (list all)		

If you have been diagnosed with or treated for the following, please indicate details below:

Diabetes
Current A1C level _____ How controlled? ○ diet alone ○ insulin (# _____ units/day) ○ oral med dosage_____
Any Complications? (describe)

Heart Disease (heart attack, chest pain, or angina)
When was the first time? Most recent occurrence?
Are you taking any heart medication? ○ Yes ○ No If so, what type and what dosage?
Have you had bypass surgery? ○ Yes ○ No When and where?
Have you had angioplasty performed? ○ Yes ○ No Physician treating your heart disease?

Cancer (any type, any malignancy, skin growths)
Please indicate the location: Oncologist name?
Radiation or chemotherapy? ○ Yes ○ No Surgery ○ Yes ○ No When/where?

High Blood Pressure
Current medication Last reading and date

Drug & Alcohol Use (excessive use of alcohol or abuse of drugs, controlled substances or prescription medication)
Dates of treatments, name and location of treatment facilities, and the names of doctors seen:

Currently using any of the above? ○ Yes ○ No Last date you used alcohol or drugs?
Any DUI/DWI's on your motor vehicle report? ○ Yes ○ No

Anxiety, Depression or Related Disorders (for which you have been diagnosed and/or treated)
Dates, name and location of treatment facilities, and the names of doctors seen:

Please continue on reverse page. *Please give as much additional information as possible, and attach additional pages as needed.*

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Medical History or Conditions *(not previously listed)* Doctor/Hospital (Name, Address & Phone)	Date/s Seen & Reason for Visit	Treatment & Results

Family Health History *(mother, father, siblings)*	**Age** *(If deceased, age at death)*	**History of Heart Disease** *(if yes, age at diagnosis)*	**History of Cancer***(All Types)* *(if yes, age at diagnosis)*

Foreign Travel (previous and/or current plans for travel outside the U.S.)
○ Yes ○ No If yes, details (when, where, how long, how often, for what purpose, when will occur next?):

Extreme Sports/Activities (auto/bike/boat/hydroplane/stock car racing, scuba diving, aviation, cave exploration, sky diving, hang gliding, bungee/parachute jumping, mountain/rock climbing, Ironman/ultra-marathons, etc.)
○ Yes ○ No If yes, details:

Aviation (flight trainee, pilot or crew member)
○ Yes ○ No Military? ○ Yes ○ No Certified? ○ Yes ○ No Commercial or private student instruction? ○ Yes ○ No
_____ # hours logged (last 12 mo) _____ # hours anticipated (next 12 mo)

Scuba Diving ○ Yes ○ No PADI certified? ○ Yes ○ No How deep? With dive master/instructor? ○ Yes ○ No
How often? Type of equipment? Organized club member? ○ Yes ○ No
Locations?

Driving History (past five years)
Charged/convicted of driving under influence of drugs/alcohol or moving violations? ○ Yes ○ No
speeding/moving violations _____ Any result in accident? ○ Yes ○ No Any result in injuries? ○ Yes ○ No

Writing Agent Full Name	Email Address	Phone

Please give as much additional information as possible regarding this case, and attach additional pages as needed.