

HEALTH SCREENING QUESTIONNAIRE

Client 1 Name: _____

Client 2 Name: _____

Male Female DOB: ____-____-____

Male Female DOB: ____-____-____

State of Birth: _____

State of Birth: _____

No Yes Ever used tobacco?

No Yes Ever used tobacco?

Last used: _____ Type: _____

Last used: _____ Type: _____

Height: ____ft. ____in. Weight: _____lbs.

Height: ____ft. ____in. Weight: _____lbs.

Physician's Name: _____

Physician's Name: _____

Overall Health: Excellent Good Fair Poor

Overall Health: Excellent Good Fair Poor

Have you ever been rejected or rated for any insurance?

Have you ever been rejected or rated for any insurance?

No Yes Type: _____

No Yes Type: _____

1. Have you ever been diagnosed by a licensed physician as having any of the following conditions?

1 2 AIDS/HIV Positive
1 2 Crest
1 2 Multiple Myeloma
1 2 Muscular Dystrophy
1 2 Scleroderma
1 2 Dementia/Confusion
1 2 Kidney Failure

1 2 ALS (Lou Gehrig's Disease)
1 2 Mental Retardation
1 2 Cystic Fibrosis
1 2 Multiple Sclerosis
1 2 Parkinson's Disease
1 2 Spinal Cord Injury
1 2 Liver Cirrhosis

1 2 Alzheimer's Disease
1 2 Metastatic Cancer
1 2 Multiple Strokes (TIA)
1 2 Neurogenic Bladder
1 2 Post Polio Paralytic
1 2 Cerebral Atrophy
1 2 Schizophrenia

2(a). Within the last 10 years, have you received medical advice, diagnosis or treatment?

(Check all that apply)

1 2 Nervous/Mental
1 2 Respiratory
1 2 Digestive
1 2 Heart/Cardiovascular
1 2 Reproductive

1 2 Blood or blood transfusion
1 2 Eyes, ear, nose, & throat
1 2 Colon/Urinary
1 2 Bones/Joints
1 2 Other: _____

2(b). If you checked any boxes in 2(a), please check all that apply. If not, skip this section:

1 2 Amputation
1 2 Angioplasty/Bypass Surgery
1 2 Arthritis
1 2 Drug or Alcohol Abuse
1 2 High Blood Pressure
1 2 Joint replacement/Fractures
1 2 Fibromyalgia
1 2 Neurological Disorder
1 2 Urinary Incontinence
1 2 Respiratory Disorders

1 2 Anemia
1 2 Dizziness
1 2 Epilepsy/Seizures
1 2 Falls
1 2 Heart Problems
1 2 Aneurysm
1 2 Cancer
1 2 COPD/Emphysema
1 2 Ulcerative Colitis/Crohn's Disease
1 2 Stroke/TIA

1 2 Autoimmune Disorder
1 2 Back Disorder/Surgery
1 2 Blindness/Degeneration
1 2 Blood Disorder
1 2 Bronchitis/Asthma
1 2 Hepatitis
1 2 Mental/ Nervous Disorder
1 2 Peripheral Vascular Disease
1 2 Depression

1 2 Diabetes Mellitus: Type ____
1 2 Elevated PSA or Prostate Disorders:
1 2 Osteoporosis with fractures:

*Insulin units per day ____
*PSA levels ____
*Bone density test t-scores ____

2 (c). If you checked any boxes in 2(a) or (b), provide details here. If not, skip this section:

1 2 Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

1 2 Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

1 2 Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

1 2 Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

3. Give details of any pending surgeries/test that have been recommended but not yet performed:

1 2 Prognosis: _____ Date: _____

Treatments: _____ Diagnosis: _____

Medications: _____

1 2 Prognosis: _____ Date: _____

Treatments: _____ Diagnosis: _____

Medications: _____

4. List all *prescription* medications taken over the past 12 months.

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

1 2 Medication: _____ Amount: _____ Currently Taking?

How Long Taking: _____ Reason Prescribed: _____

Long-Term Care Field Underwriting

Client 1:

Client 2:

Drivers License Number: _____
 State of Issue: _____
 Expiration Date: _____
 State of Birth: _____
 Years at Residence: _____

Drivers License Number: _____
 State of Issue: _____
 Expiration Date: _____
 State of Birth: _____
 Years at Residence: _____

(Check if 'yes')

1 2 Do you have any trouble performing Instrumental Activities of Daily Living?
 (Examples: preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, using a telephone, etc.)

1 2 Do you have any trouble performing Activities of Daily Living?
 (Examples: activities related to personal care and include bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating)

For Advisor Use Only

Quote 1

Daily Benefit Desired: \$ _____ Individual Joint Tax Qualified Non-tax qualified
 Benefits: Post Acute Nursing Home Assist. Living Home Health Comprehensive
 Deductible: 0 days 30 days 60 days 90 days 180 days 1 yr.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years Life
 Riders: COLA: Simple Compound ROP WOP N/A

Quote 2

Daily Benefit Desired: \$ _____ Individual Joint Tax Qualified Non-tax qualified
 Benefits: Post Acute Nursing Home Assist. Living Home Health Comprehensive
 Deductible: 0 days 30 days 60 days 90 days 180 days 1 yr.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years Life
 Riders: COLA: Simple Compound ROP WOP N/A

Quote 3

Daily Benefit Desired: \$ _____ Individual Joint Tax Qualified Non-tax qualified
 Benefits: Post Acute Nursing Home Assist. Living Home Health Comprehensive
 Deductible: 0 days 30 days 60 days 90 days 180 days 1 yr.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years Life
 Riders: COLA: Simple Compound ROP WOP N/A

Quote 4

Daily Benefit Desired: \$ _____ Individual Joint Tax Qualified Non-tax qualified
 Benefits: Post Acute Nursing Home Assist. Living Home Health Comprehensive
 Deductible: 0 days 30 days 60 days 90 days 180 days 1 yr.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years Life
 Riders: COLA: Simple Compound ROP WOP N/A

Life Insurance Field Underwriting

Client 1:

Drivers License Number: _____

State of Issue: _____ Expiration Date: _____

State of Birth: _____

Occupation: _____ Years: _____

Employer Add.: _____

Years at Residence: _____ Net Worth: _____

Client 2:

Drivers License Number: _____

State of Issue: _____ Expiration Date: _____

State of Birth: _____

Occupation: _____ Years: _____

Employer Add.: _____

Years at Residence: _____ Net Worth: _____

(Check if 'yes')

1 2 Actively working? If no, please explain _____

1 2 Does the client have any family history (parent, sibling) of death before age 70 due to cardiovascular, cerebral vascular disease, diabetes, or cancer? If yes, member/age/cause: _____

1 2 Within the last 5 years has the client had a reckless driving, or DUI/DWI violation? If yes, date: _____

1 2 Any prior convictions? If yes, date: _____

1 2 Does the client participate in any dangerous activities/avocations (scuba diving, racing, skydiving, etc)? If yes, what: _____

1 2 Is the client intending to travel to any foreign country (excluding Canada)? If yes, when & length of stay: _____

1 2 U.S. Citizen? No Yes Green Card? No Yes Applying for Citizenship?

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Quote 1

Term Years: _____ Permanent death benefit: (A) Level (B) Increasing
Face Amount: \$ _____
Annual Premium: \$ _____
Single Premium: \$ _____
Monthly Benefit: \$ _____
Riders: Waiver of Premium Accidental Death & Dismemberment
 Return of Premium Guarantee No Lapse 100 or 120

Quote 2

Term Years: _____ Permanent death benefit: (A) Level (B) Increasing
Face Amount: \$ _____
Annual Premium: \$ _____
Single Premium: \$ _____
Monthly Benefit: \$ _____
Riders: Waiver of Premium Accidental Death & Dismemberment
 Return of Premium Guarantee No Lapse 100 or 120

Quote 3

Term Years: _____ Permanent death benefit: (A) Level (B) Increasing
Face Amount: \$ _____
Annual Premium: \$ _____
Single Premium: \$ _____
Monthly Benefit: \$ _____
Riders: Waiver of Premium Accidental Death & Dismemberment
 Return of Premium Guarantee No Lapse 100 or 120

Quote 4

Term Years: _____ Permanent death benefit: (A) Level (B) Increasing
Face Amount: \$ _____
Annual Premium: \$ _____
Single Premium: \$ _____
Monthly Benefit: \$ _____
Riders: Waiver of Premium Accidental Death & Dismemberment
 Return of Premium Guarantee No Lapse 100 or 120

Disability Income Field Underwriting

Client 1:

Drivers License Number: _____

State of Issue: _____ Expiration Date: _____

State of Birth: _____

Occupation: _____ Years: _____

Employer Add.: _____

Years at Residence: _____ Net Worth: _____

Client 2:

Drivers License Number: _____

State of Issue: _____ Expiration Date: _____

State of Birth: _____

Occupation: _____ Years: _____

Employer Add.: _____

Years at Residence: _____ Net Worth: _____

(Check if 'yes')

- Actively working? If no, why? _____
- Are you receiving Worker's Compensation/Disability?
- Current member of National Guard or military?
- Does the client participate in any dangerous activities/avocations (scuba diving, racing, skydiving, etc)?
If yes, what: _____
- Parents, brothers/sisters died from cancer, diabetes or heart disease before age 60?
- Currently pregnant?
- Reproductive disorder, miscarriage, stillbirth, or Cesarean section delivery?
- Have you previously been declined for Disability Income Insurance?
Reason for decline: _____

Probable Occupation Class

- White Collar (Administration) Blue Collar (Light Labor)
- White Collar (Technical) Blue Collar (Heavy Labor)

ALL APPLICATIONS FOR DISABILITY INCOME INSURANCE COVERAGE MUST INCLUDE:

- **Income tax returns for past 2 tax years including all schedules**
- **2 most recent paystubs**

All W-2's AND 1099's For Advisor Use Only

Quote 1

Gross Earned Income: \$ _____ Monthly Benefit Desired: \$ _____ COLA: No Yes
 Elimination Period: 30 days 60 days 90 days 180 days 1 yr. 2 yrs.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years to 65
 SSDI Waiver No Yes

Quote 2

Gross Earned Income: \$ _____ Monthly Benefit Desired: \$ _____ COLA: No Yes
 Elimination Period: 30 days 60 days 90 days 180 days 1 yr. 2 yrs.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years to 65
 SSDI Waiver No Yes

Quote 3

Gross Earned Income: \$ _____ Monthly Benefit Desired: \$ _____ COLA: No Yes
 Elimination Period: 30 days 60 days 90 days 180 days 1 yr. 2 yrs.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years to 65
 SSDI Waiver No Yes

Quote 4

Gross Earned Income: \$ _____ Monthly Benefit Desired: \$ _____ COLA: No Yes
 Elimination Period: 30 days 60 days 90 days 180 days 1 yr. 2 yrs.
 Benefit Period: 1 Year 2 Years 3 Years 4 Years 5 Years to 65
 SSDI Waiver No Yes