INSIGHT•INNOVATION•SERVICE

Pre-Screening Questionnaire

Proposed Insured:_____ Agent Name:_____
Policy Type:_____ LTC Rider:_____ Face Amount:_____ Writing State:_____
Date of Birth:_____ Height:_____ Weight:_____ US Citizen:_____ If No, Citizen of:_____
Nicotine Use (ever):_____ Type:_____ Frequency:_____ Date of Last Use:_____
Marijuana Use (ever):_____Type:_____ Frequency:_____ Date of Last Use:_____
Recreational or Medicinal:_____

Please give complete details of all YES answers to questions, including but not limited to all dates, diagnoses, duration, outcome, treatments, and medications prescribed. Please provide treating doctor's name, address, and phone.

Have you ever had, been told by a member of the medical profession that you have, or have been diagnosed or treated for:			**Details:**
1.	High blood pressure, heart attack, heart murmur, palpitation, anemia or any disease or abnormality of the heart, blood vessels or blood?	☐ Y ☐ N	
2.	Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐ Y ☐ N	
3.	Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐ Y ☐ N	
4.	Cancer, tumor, polyp or cyst?	☐ Y ☐ N	
5.	Any physical deformity or amputation?	☐ Y ☐ N	
6.	Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐ Y ☐ N	
7.	Any immune deficiency disorder, AIDS, AIDS related Complex (ARC), HIV, or tested positive on an AIDS/HIV-related test?	☐ Y ☐ N	
8.	Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs, or other substance or joined an organization for alcohol or drug dependence or abuse?	☐ Y ☐ N	
9.	Have you had any hospitalizations in the past 12 months?	☐ Y ☐ N	
10.	Any moving violations or driving under the influence or driving while intoxicated, etc., in the past 10 years? (If yes, please include dates and violations)	☐ Y ☐ N	
11.	Has any application for life, health, disability, or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐ Y ☐ N	
12.	Are you currently taking any prescriptions, vitamins, supplements, or over the counter medications?	☐ Y ☐ N	
13.	Are you going to be traveling outside of the United States in the next 2 years, business or pleasure? (If yes, advise destination(s), duration of stay, and purpose of travel)	☐ Y ☐ N	
14.	Do you participate in any extreme sports? Underwater diving, aerial sports, motor sports, etc.	☐ Y ☐ N	
15.	Are you a private pilot? (If yes, what type of plane, how many hours flown per year and total to date, what certifications do you hold)	☐ Y ☐ N	

Family History:

	Age(s) if Living	**Age(s) at Death**	**Cause(s) of Death**	**Medical History and Age of Diagnosis**
Father				Cancer _____ Heart Disease _____ Diabetes _____
Mother				Cancer _____ Heart Disease _____ Diabetes _____
Brothers				Cancer _____ Heart Disease _____ Diabetes _____
Sisters				Cancer _____ Heart Disease _____ Diabetes _____