General Medical Questionnaire

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ ❒ M ❒ F Birth or Age: _____
Face Amount: _____ Max. Premium: $_____/year ❒ UL ❒ WL ❒ Term ❒ Survivorship
Do you currently smoke cigarettes? ❒ Y ❒ N If no, did you ever smoke: ❒ Never ❒ Quit (Date):
_____
Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): ❒ Y ❒ N
If Yes, please provide details:
_____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last:
_____

Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____
Has the Proposed Insured experienced a change in weight greater than 10 pounds in the past 12 months? Yes No
If YES, please specify: Pounds Lost/Pounds Gained Reason

Has the Proposed Insured EVER been diagnosed by, or received treatment from, a licensed member of the medical profession for any of the following? If YES, please circle ALL that apply and provide details below.

High Blood Pressure
Heart Attack
Chest Pain
Heart Murmur
Diabetes
High Cholesterol
Cancer / Tumor / Polyp
Asthma / Bronchitis
Emphysema
Sleep Apnea
Seizures
Stroke
Paralysis
Multiple Sclerosis
Parkinson's Disease
Alzheimer's Disease
Memory Loss
Colitis
Cirrhosis
Hepatitis
Arthritis

Other than as indicated above, has the Proposed Insured EVER been diagnosed by a licensed member of the medical profession with any disease or disorder of any of the following? If YES, please circle ALL that apply and provide details below.

Heart
Arteries / Veins
Lungs / Respiratory System
Gastrointestinal / Digestive System
Liver / Pancreas
Kidney / Bladder
Prostate
Reproductive Organs
Brain / Nervous System
Blood
Lymph Nodes
Immune System
Thyroid/ Other Glands
Eyes
Ears / Nose / Throat
skin
Muscles / Bones / Joints
Emotional / Psychological Disorder

Other than as indicated previously, within the past five years, has the Proposed Insured been diagnosed by any physician, practitioner or health facility as having had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility?

Is the Proposed Insured currently receiving any treatment by a licensed member of the medical profession or taking any prescription or nonprescription medications or supplements?

Does the Proposed Insured have any surgery, medical tests, treatment, or visits with a health professional scheduled in the next six months?

Has the Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having AIDS or ARC caused by the HIV infection or other sickness or condition derived from such infection?

Has the Proposed Insured ever used cocaine, heroin, barbiturates, amphetamines, hallucinogens, or controlled substances except as prescribed by a health professional?

Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a licensed member of the medical profession or support group?

Has the Proposed Insured ever been arrested for driving under the influence (DUI) or for driving while intoxicated?

To the best of your knowledge and belief, has a parent or sibling ever had: heart disease, coronary artery disease, vascular disease, stroke/cerebrovascular disease, diabetes, cancer, or kidney disease? If YES, please provide details below.

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			