

Disability and Life Insurance Pre-Underwriting Questionnaire

Name: _____ DOB: ____/____/____ Female Male Annual Income: \$ _____ Monthly Benefit: \$ _____

Occupation Information

Occupation: _____ Years in Occupation: ____

Do you supervise employees? Yes No If yes, how many? _____

Current Employer: _____ Years Employed: ____

Are you an owner? Yes No

Are you a Federal, State or Municipal Employee? Yes No

Do you work from your home? Yes No

Do you have any part-time jobs? Yes No

If you answered 'yes' to any of the questions above, please provide details below (Number of employees, job duties, travel required, etc.):

What is the business type: **None**

What is your % of ownership? 0% Number of Employees: _____

Other Disability Income Insurance

Do you have any Group Disability Insurance? Yes No

Do you have any Individual Disability Insurance? Yes No

Do you have any Association Disability Insurance? Yes No

Will this policy replace any Disability Insurance? Yes No

If you answered 'yes' to any of the questions above, please provide details below (amount, elimination period, benefit period, riders, etc.):

Who will pay the premium for this policy? Individual Employer

Who pays the premiums for any Group Ins.? Individual Employer

Medical/Risk History

Height: _____ Weight: _____

Used any form of tobacco in the last 12 months? Yes No

Are you currently taking any medication(s)? Yes No

Are you pregnant? Yes No

Do you have a history of:

Neck or back disorders/Cancer/Heart attacks? Yes No

Mental/Nervous Condition/Liver/Lungs/Kidney disease? ... Yes No

Diabetes/High Cholesterol/Hypertension? Yes No

In the last five year have you seen any:

Physicians? Yes No

Chiropractors? Yes No

Counselors/Psychiatrists? Yes No

Do you participate in any risky sports? Yes No

Scuba, Sky Diving, Bungee Jumping, Rock Climbing, Racing

If you answered 'yes' to any of the questions above, please provide details below, using the back or another sheet if necessary:

Family History

	Age	Living (state of health)	Age	Deceased (Cause of death)
Father				
Mother				
Brothers				
Sisters				

Do any parents/siblings have or have a history of; cancer, diabetes, or heart disease? Yes No

If yes, details: _____