

Jeff Darnell
jdarnell@sourcebrok.com
Source Brokerage, Inc.
(800)543-7167 ext. 225
(800)856-3494 Fax

CORONARY ARTERY DISEASE QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____

1. Which of the following procedures was completed (check all that apply):

- Coronary Artery Bypass Graft (CABG)
Date (month & year): _____
- Angioplasty / Stent
Date (month & year): _____
- Other (details): _____
Date (month & year): _____

2. How many arteries were involved? _____

3. Have you had a heart attack? Yes No
If yes, give date(s) (month & year): _____

4. Last cholesterol reading (if known): _____

5. Date of last stress test (month and year) and results: _____

6. List all medications currently being taken: _____

Name of physician with cardiac records: _____

Address: _____

Date last seen: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

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DIABETES QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____

1. Age at onset of diabetes? _____

2. What is the method of control? _____

3. Please indicate if you have had any of the following:

- EKG Abnormality
- insulin reaction
- diabetic coma
- eye trouble
- protein in urine
- skin ulceration
- amputation
- neuropathy / loss of feeling
- other _____

4. How often do you monitor blood sugar levels and what was the most recent reading?

5. Indicate most recent blood pressure reading (to the best of your knowledge): ____ / ____

6. Last time you visited a physician? _____

7. Is your cholesterol below 200? _____

Name and address of all physicians/hospitals with medical records: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

Witnessed by: _____

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CANCER QUESTIONNAIRE

Name: _____ Date of Birth: _____
Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____

1. Type of cancer:

- Bladder
- Breast
- Cervical
- Colon or rectal
- Melanoma
- Prostate
- Skin
- Other _____

2. Date diagnosed (month & year) _____

3. Stage of cancer:

- 1 2 2a 2b 2c 3 3a 3b 4

4. Please check all treatment(s) received and date completed (month & year):

- Surgery _____
- Chemotherapy _____
- Radiation _____
- Hormone _____
- Other (please specify) _____

5. Has there been any evidence of recurring cancer? Yes No

If yes, month & year _____ Location _____

6. Please list all medication currently being taken: _____

7. If colon or rectal cancer: Dukes scale A B1 B2-3 C1 C2 D

8. If melanoma: Clarks level I II III IV V

Location of melanoma and depth : _____

9. If prostate cancer, what was most recent PSA test result? _____

Gleason's Grade 2-5 6 7 8-10

Name of physician with cancer records and date last seen: _____

Address: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

Witnessed by: _____

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NERVOUS DISORDER QUESTIONNAIRE

Name: _____ Date of Birth: _____
Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____
Occupation: _____

1. What is the diagnosis?
 Depression
 Manic depression (Bipolar)
 Anxiety / Panic attacks
 Other _____
2. Has applicant ever attempted suicide? Yes No
If yes, number of times _____ Date(s): _____
3. Has the applicant ever been hospitalized for psychiatric reasons? Yes No
If yes, number of times _____ Date(s): _____
4. Has the applicant lost work due to psychiatric reasons within the last 12 months?
 Yes No If yes, how long? _____
Are you currently disabled? Yes No
5. Is applicant currently taking medication(s)? Yes No
If yes, list medication(s): _____

6. List any other illness or injury: _____

7. Name of doctor with psychiatric records and date last seen: _____
Address: _____

Notes/comments: _____

Agent: _____
Address: _____
Phone: _____ Fax: _____

Signature of Proposed Insured: _____ Date: _____

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DRIVING QUESTIONNAIRE

Name: _____ Date of Birth: _____

Cigarette Smoker: Yes No Quantity per day: _____

Occupation: _____

1. Do you currently hold a valid driver's license? Yes No

If yes, State: _____

License number: _____ Expiration date: _____

If no, date of suspension: _____ Length of suspension: _____

2. List all speeding violations within the last five years:

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

Month / year _____ Amount over limit: _____

3. List all moving violations other than speeding within the last five years:

Month / year: _____ Violation: _____

Month / year: _____ Violation: _____

Month / year: _____ Violation: _____

Month / year: _____ Violation: _____

4. List all accidents involving property damage within the last five years:

Month / year: _____

Month / year: _____

Month / year: _____

5. Have you ever been treated for alcohol or substance abuse? Yes No

If yes, Month / year _____ Where? _____

Notes/comments: _____

Agent: _____

Address: _____

Phone: _____ Fax: _____

Signature of Proposed Insured: _____ Date: _____

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DRUG USAGE QUESTIONNAIRE

Name: _____ Date of Birth: _____

Cigarette Smoker: Yes No Quantity per day: _____

- | 1. Have you ever used any of the following drugs: | <u>YES</u> | <u>NO</u> | <u>Date last used</u> |
|---|------------|-----------|-----------------------|
| a) <u>Opiate derivatives</u> (e.g. Heroin, Morphine, Methadone, Demerol, Codeine, Percodan, Dilaudid) | [] | [] | _____ |
| b) <u>Barbiturates</u> (eg. Amytal, Seconol, Nembutal, Phenobarbital) | [] | [] | _____ |
| c) <u>Marijuana</u> , hashish | [] | [] | _____ |
| d) <u>Amphetamines</u> (e.g. Benzadrine, Dexadrine, Methadrine) | [] | [] | _____ |
| e) <u>Cocaine</u> | [] | [] | _____ |
| f) <u>Hallucinogens</u> (e.g. LSD, DMT, Mescaline, Peyote, PCP) | [] | [] | _____ |
| g) <u>Sedatives</u> and Tranquilizers (e.g. Librium, Valium, Dalmane, Qualude) | [] | [] | _____ |
| h) <u>Other(s)</u> _____ | [] | [] | _____ |

Please give details:

TYPE	USUAL QUANTITY	FREQUENCY OF USE
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. List all medications currently being taken: _____

3. Do you currently use any drugs (other than listed in question 2)? Yes No
 If yes, which one(s) _____

4. Have you ever sought medical treatment because of drug or alcohol use? Yes No
 If yes, state date(s) and name(s) of doctor and institution consulted:

5. Do you currently use alcohol? Yes No
 If yes, quantity and how often? _____

NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, which is a crime.

I hereby verify that the above questions have been answered by me fully, completely and truthfully to the best of my ability.

Signature of Proposed Insured: _____ Date _____

Witnessed by: _____

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ALCOHOL USAGE QUESTIONNAIRE

Name: _____ Date of Birth: _____

Cigarette Smoker: Yes No

1. Do you presently consume alcohol beverages? YES NO

If "NO," date of last drink: _____ If "YES," list quantity: _____

		BEER	WINE	LIQUOR
QUANTITY:	Daily:	_____	_____	_____
	Weekly:	_____	_____	_____
	Monthly:	_____	_____	_____

2. Did you ever drink substantially more than at present? YES NO

Dates: From: _____ To: _____

If "YES," list quantity:

		BEER	WINE	LIQUOR
QUANTITY:	Daily:	_____	_____	_____
	Weekly:	_____	_____	_____
	Monthly:	_____	_____	_____

Why did you change your drinking habits? _____

3. Are you active in A.A. or other recovery groups? YES NO How long? _____

4. Have you ever consulted a doctor or received treatment because of your alcohol use? YES NO

If "YES", indicate name and address of any doctor, hospital or treatment center: _____

5. Have you ever been charged with driving under the influence of alcohol? YES NO

If "YES", give details and drivers license number: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

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STROKE/TIA QUESTIONNAIRE

Name: _____ Date of Birth: _____
Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____
Occupation: _____

1. Number of strokes / TIA's: _____
2. Date(s) of stroke / TIA (month & year) _____
3. Cause of stroke / TIA (if known): _____
4. Do you have any residual neurological deficits?
 - Slurred speech
 - Arm or leg weakness
 - Memory impairment
 - Other _____
5. Have you ever had carotid artery surgery?
 - Yes No If yes, date(s): _____
6. Last cholesterol reading (if known): _____
7. Last blood pressure reading (if known): _____ / _____
8. List all medications currently being taken: _____

9. List any other illness or impairment: _____

Name of physician with stroke / TIA records: _____
Address: _____

Notes/comments: _____

Agent: _____
Address: _____
Phone: _____ Fax: _____

Signature of Proposed Insured: _____ Date: _____

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TOBACCO USE QUESTIONNAIRE

Applicant Name: _____ Date of Birth: _____
Height _____ Weight: _____

1. In the past twelve months I have used:					Date last used
Cigarettes	# _____	Per day	# _____	Per week	# _____ Per Month _____
Cigars	# _____	Per day	# _____	Per week	# _____ Per Month _____
Pipe	# _____	Per day	# _____	Per week	# _____ Per Month _____
Chewing	# _____	Per day	# _____	Per week	# _____ Per Month _____
Smokeless	# _____	Per day	# _____	Per week	# _____ Per Month _____

2. Age when you started using tobacco: _____
3. Have you ever changed the type of tobacco products used or amount used? Yes No
If yes, clarify type of change / amount / date: _____

4. Are you currently using a nicotine patch or any nicotine products other than stated in question #1?
 YES NO

Notes / comments: _____

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I hereby verify that the above questions have been answered by me fully, completely and truthfully to the best of my ability.

Signature of Proposed Insured

Date

Witness

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CONFIDENTIAL FINANCIAL QUESTIONNAIRE

The following financial disclosures are made for the purpose of establishing insurability in connection with a pending Life Insurance Application on my life. They are furnished as a true and accurate statement of my financial condition on _____ 20_____.

ASSETS		LIABILITIES	
Cash	\$ _____		
Notes/Accounts Receivable	\$ _____	Notes/Accounts Payable	\$ _____
Real Estate	\$ _____	Mortgages	\$ _____
Business Net Worth	\$ _____	Taxes and interest due	\$ _____
Stocks and Bonds <i>(not included above)</i>	\$ _____	Other Liabilities <i>(describe)</i>	\$ _____
Personal Property <i>(auto, furniture, etc.)</i>	\$ _____	Total Liabilities	\$ _____
Other Assets <i>(describe)</i>	\$ _____		
TOTAL	\$ _____	NET WORTH	\$ _____

Income:	Last Year	Year Prior
Annual Salary	\$ _____	\$ _____
Bonus	\$ _____	\$ _____
Dividends, etc.	\$ _____	\$ _____
Other Income <i>(describe)</i>	\$ _____	\$ _____
Total	\$ _____	\$ _____

Need and purpose for coverage:

I understand that the Company will rely on the above statement in determining the need and justification for the insurance applied for, I represent that all answers are true and accurate to the best of my knowledge and belief as of the date of application for life insurance.

Signature of Proposed Insured _____ Date _____

Witnessed by _____

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FOREIGN NATIONALS OR FOREIGN TRAVEL QUESTIONNAIRE

Name: _____ Date of Birth: _____

Cigarette Smoker: Yes No Quantity per day: _____

1. Are you a U.S. citizen? Yes No (If yes, proceed to Part 2).
 - a) How long have you lived in the U.S.? _____
 - b) What is your Alien Registration Card (green card) Number? _____
 - c) If no green card, what type of visa do you have? _____
 - d) Do you own a home in the U.S.? _____
If yes, address: _____
 - e) Do you own a home in a foreign country? Yes No
 - f) Does your family live with you? Yes No
2. In the past five years, have you traveled outside the United States? Yes No
 - a) If yes, where? (City, Country) _____
 - b) Purpose of travel? Business Pleasure Other
If other explain/details: _____
 - c) How often? _____
 - d) Average period of time for each trip: _____
 - e) When was the last trip? _____
3. Do you plan to travel outside of the United States? Yes No
 - a) If yes, where? (City, Country) _____
 - b) Purpose of travel? Business Pleasure Other
If other explain/details: _____
 - c) How often? _____
 - d) Average period of time for each trip: _____
 - e) When will the next trip be? _____
4. Have you ever been convicted of a crime in another country? Yes No
If yes, give details: _____

5. Occupation/Duties: _____
6. Business Address: _____

Signature of Proposed Insured: _____ Date: _____

Witnessed by: _____