



# INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

## *Drug Use Questionnaire*

Information gathered will be used in the evaluation of the insurability of the applicant. Offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

Agent's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Male ( ) Female ( ) Height \_\_\_\_\_ Weight \_\_\_\_\_ Smoker ( ) Non Smoker ( )

Amount of Coverage \$ \_\_\_\_\_ Product Type \_\_\_\_\_

1. In the past five years, have you used:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| (a) barbiturates, sedatives or tranquilizers habitually? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) LSD, marijuana, or any amphetamine?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Heroin, morphine, or other narcotic drug?            | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Other drug not listed above?                         | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, give details:

Type	How Often Used	Dosage or Amount Used	Dates used	
			From:	To:

2. If treatment received: When? \_\_\_\_\_

Where? \_\_\_\_\_

name

address

Nature of treatment? \_\_\_\_\_

Name of attending physician? \_\_\_\_\_

3. Are you now an active member or participant in a support group? [ ] Yes [ ] No