



# INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

## *Preferred Risk 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. Please detail the client's family history:

Family Member	Age	If Living State of Health or Cause of Death	Age at Death
Father			
Mother			
Brother (s)			
Sister (s)			

2. Detail the client's medical history (check all that apply):

Cancer history /  Heart history/Condition

Diabetes history /  Alcohol or drug abuse history

High blood pressure If yes, please detail:

Current reading \_\_\_\_\_

Highest reading \_\_\_\_\_

Type of treatment \_\_\_\_\_

Elevated cholesterol history If yes, please detail:

Current reading \_\_\_\_\_

HDL reading or ratio \_\_\_\_\_

Highest cholesterol reading \_\_\_\_\_

Type of treatment \_\_\_\_\_

Electrocardiogram (EKG) If taken within past year:

Results:  Normal  Other \_\_\_\_\_

Stress EKG or Thallium If taken within past year, detail:

Results:  Normal  Other \_\_\_\_\_

Sigmoidoscopy If taken within past year, please detail:

Results:  Normal  Other \_\_\_\_\_

Prostate exam If taken within the past year, detail:

Results:  Normal  Other \_\_\_\_\_

Mammogram If taken within the past year, please detail:

Results:  Normal  Other \_\_\_\_\_

3. Has the client had a standard medical checkup within the past year?  Yes  No  
If yes, please detail: Results:  Normal  Other \_\_\_\_\_

4. Does the client exercise three or more times per week?  Yes  No  
If yes, please detail \_\_\_\_\_

5. Does the client take vitamins?  Yes  No  
If yes, please detail \_\_\_\_\_

6. Has the client received any driving violations during the past three years?  Yes  No  
If yes, please detail date and type \_\_\_\_\_

7. Does the client participate in aviation / avocation activities?  Yes  No  
If yes, please detail \_\_\_\_\_

8. Client's occupation \_\_\_\_\_

9. Please list any other illnesses or impairments; along with any and all medications currently being taken, include the dosage and frequency of each: \_\_\_\_\_  
\_\_\_\_\_