CHAMPION AGENCY, INC.
Innovative services for insurance brokers

Life Pre Screen Underwriting Questionnaire

Name: ________________________________

❑ Male ❑ Female DOB: ____/____/____

Height: _________ Weight: __________

Tobacco Use? ❑ Yes ❑ No
If yes, type & quantity: ____________
____

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1. Please list illnesses, diseases, disorders, surgeries, impairments, etc.:
____
____
____
Please provide ALL details:
____
____
____
____
____
____
____
____
____
2. Please provide month and year the illness was diagnosed:
____
____
3. What type of treatment was administered?
   - ❑ Surgery:
   ____
   ____
   - ❑ Medication:
   ____
   ____
   - ❑ Other type of treatment:
   ____
   ____
4. When was the last time you visited a physician about this disorder?
   - ❑ 0 to 6 months
   - ❑ 6 to 12 months
   - ❑ 12 to 24 months
   - ❑ over 24 months ago
5. Have you had any complications as a result of this disorder? Provide details:
____
____
____
____
____
____
6. Last Cholesterol Reading: __________
Currently treated? ❑ Yes ❑ No
Medication: ___________________
How long under control? ___________
7. Last Blood Pressure Reading:
_____/_____
Currently treated? ❑ Yes ❑ No
Medication: ___________________
How long under control? ___________
8. Do you regularly exercise 3 or more times per week?
   - ❑ Yes Type: _______________
   - ❑ No
9. Has either parent or any sibling died before the age of 65 other than by accident?
   - ❑ Yes Cause: ______________
   - ❑ No
10. Please list any other illness or impairment:
____
____
____
____
11. List all other medications currently being taken not mentioned above:
____
____
____
____
12. Last life insurance applied for:
Company: ______________________
Date: _________________________
Result: ❑ Declined ❑ Postponed
❑ Rated Table: _________

COMMENTS: ______________________
____
____
____

CHAMPION AGENCY, INC.
Innovative services for insurance brokers

DI PRE-SCREENING QUESTIONNAIRE

Date:

AGENT INFORMATION

Name: | Address:

Phone: | Fax: | Send Proposal Via: □ Fax □ Email:_______________________

CLIENT INFORMATION

Full Name: | DOB: | Resident State:

MEDICAL HISTORY

1. Do you presently use tobacco or nicotine in any form?........... □ Yes □ No | Height: | Weight: | US Citizen? □ Yes □ No
   ☞ Date of Last Use___________ ☞ Type__________________________________

PROVIDE DETAILS TO ALL "YES" ANSWERS IN COMMENTS SECTION BELOW	Yes	No
3. Are you currently taking any medication?	□	□
4. Do you have a history of:		
(a) Neck or back disorders?..	□	□
(b) Mental/Nervous Conditions?..	□	□
(c) Diabetes, High Cholesterol, Hypertension?..	□	□
5. In the last 5 years, have you seen any:		
(a) Physicians?..	□	□
(b) Chiropractors?..	□	□
(c) Counselors/Psychiatrists?..	□	□
6. Do you have any other medical history not disclosed above? Provide all details below..................................	□	□

INFORCE DISABILITY INCOME INSURANCE

TYPE CODES: **(I)** Individual; **(S)** Social Security Substitute; **(G)** Group; **(A)** Association; **(OE)** Overhead Expense; **(DBO)** Buy-Out; **(O)** Other-explain

Type	Monthly Amount	Benefit Period	Waiting Period	Who Pays Premiums?	GROUP		Will coverage be replaced?
					Benefit Cap Max?	% of Income	
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No

OCCUPATION DETAILS

1. Occupation: | # of Yrs: | Professional Designation, Specialty, Degree:

2. Duties (provide % of time spent doing each):

Administration	Travel	Sales	Manual Labor	Managerial	Other (specify duty)

PROVIDE DETAILS TO ALL "YES" ANSWERS IN COMMENTS SECTION BELOW	Yes	No
3. Are you self employed? (If yes, # of employees: ___________)..	□	□
4. Do you work from your home? Do clients visit you there regularly? If yes, what percentage of time for each?.........	□	□
5. Are you a Federal, State, or City employee?..	□	□

FINANCIAL INFORMATION

1. Gross Earnings (after expenses if self-employed)

Current Year to Date	Last Year	2 Years Ago
$	$	$

PROVIDE DETAILS TO ALL "YES" ANSWERS IN COMMENTS SECTION BELOW	Yes	No
2. Do you have annual unearned income (e.g., dividends, interest) that exceeds 10% of earned income?.....................	□	□
3. Does your net worth exceed $3,000,000?..	□	□
4. Did you receive any bonuses in the last 3 years (if yes, provide amount in comments)?..	□	□

COMMENTS

CHAMPION AGENCY, INC.
Innovative services for insurance brokers

LTC PRE-SCREENING QUESTIONNAIRE

Date:

AGENT INFORMATION		
Name:	Address:	
Phone:	Fax:	Send Proposal Via: □ Fax □ Email:______________________

CLIENT INFORMATION		
Full Name:	DOB:	Resident State:

MEDICAL HISTORY			
1. Have you used tobacco products in the last 12 months?.......................... □ Yes □ No ☞ Date of Last Use___________ ☞ Type________________________________	2. Height:	3.Weight:	4.US Citizen? □ Yes □ No

PROVIDE DETAILS TO ALL "YES" ANSWERS IN COMMENTS SECTION BELOW

5. Within the last five years have you received medical advice, diagnosis, or treatment, or consulted with a member of the medical profession for any of the following conditions	Yes	No
A. Circulatory disorders	□	□
B. Endocrine and pituitary disorders	□	□
C. Cancers	□	□
D. Genital urinary disorder	□	□
E. Gastrointestinal disorders	□	□
F. Neurological disorder	□	□
G. Blood disorders	□	□
H. Musculoskeletal disorders	□	□
I. Respiratory disorders	□	□
J. Eye and ear disorders	□	□
K. Substance abuse	□	□
6. Do you use any assistive or mechanical devices?..	□	□
7. Have you ever received home health care or been confined to a nursing home or rehabilitation facility..................	□	□
8. Do you require human assistance or supervision in performing any of your activities of daily living?	□	□
9. Have you had a complete physical exam within the past 18 months?	□	□

DETAILS to questions 5-9:

Question #	Diagnosis	Diagnosis date	Treatment

List all prescription medications prescribed over the past 12 months

COMMENTS