CLASSIFICATION QUESTIONS

Agent's Name _____ **Agent's Phone** _____ **Fax/E-mail** _____

Client Name		D.O.B.	Citizenship
Height ___ ft. ___ in.	**Weight** _____ lbs.	**Sex** ( ) Male ( ) Female	**Purpose of Insurance (Business/Personal - Income RPL, Buy/Sell, etc.)**

Plan of Insurance / Amount Desired ( ) Term ( ) UL $ _____	Anticipated Premium $_____ Class: Super-Preferred Preferred Super Standard Standard

- **Lost weight in last year?** ( ) Yes ( ) No **How much:** _____ lbs.
- **Tobacco use in any form?** ( ) Yes ( ) No **If yes, give form and frequency:**_____
- **Recently stopped using tobacco?** ( ) Yes ( ) No **If yes, when:**_____
- **Adverse motor vehicle report?** ( ) Yes ( ) No **If yes, please detail:**_____
- **Any family history of disease?** ( ) Yes ( ) No **If yes, list family member , age if living or age at death and cause (heart disease,**
  Adopted? ( ) Yes **vascular disease, cancer)**
  _____
  _____

- **High blood pressure or elevated cholesterol?** ( ) Yes ( ) No **If yes, current reading: BP** _____ **/ Chol** _____
  Highest reading: BP _____ **/ Chol** _____ **HDL reading or ratio:** _____
- **Ever been hospitalized?** ( ) Yes ( ) No **If yes, please detail:** _____
_____

- **Any history of the following? (check all that apply)**

( ) **Cancer history** **If yes, date diagnosed?** _____ **Stage of cancer at diagnosis?** _____

( ) **Diabetes history** **If yes, date diagnosed?** _____ **Last A1C reading?** _____

( ) **Alcohol or drug abuse history** **If yes, date diagnosed?** _____ **Last date of in-treatment?** _____

( ) **Heart history / condition** **Heart attack - date?** _____ **By-pass - how many vessels and date?** _____

( ) **Sleep apnea** **If yes, date diagnosed?** _____ **On CPAP?** _____

- **Does the client have foreign travel plans?** ( ) Yes ( ) No **If yes, when, where and for what duration? :** _____
_____

- **Does the client participate in aviation or hazardous activities?** ( ) Yes ( ) No **If yes, details:** _____
_____

- **Has the client had a routine medical check-up within the past year?** ( ) Yes ( ) No **If yes,** ( ) Normal ( ) Other _____

- **List other illnesses or impairments:**_____
_____

- **List any prescribed medications taken (include dosage and frequency):** _____

The above information is for preliminary underwriting purposes only and will not be made part of any contract.

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MCQ - (6.2020)