

Underwriting Questionnaire

Gastric Bypass

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

Male Female Face Amount _____ Max Premium \$ _____ /yr.

Term Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Date of procedure _____ Type of procedure (e.g. gastric bypass, banding, etc.) _____

Weight prior to procedure _____ Current weight _____ Has weight loss been stable/maintained Yes No

Height _____

Select and provide details if any of the following complications have occurred

- Hemorrhage _____
- Obstruction _____
- Perforation _____
- Leaks _____
- Abnormal liver function studies _____
- Hypoglycemia _____
- Anemia _____
- Nutritional deficiencies _____
- Vomiting or nausea _____
- Change in bowel habits/diarrhea due to dietary modifications _____
- Failure to lose weight _____
- Problems retaining weight _____
- Dumping syndrome _____

Any history, past or present, of associated chronic disease including diabetes, hypertension, hyperlipidemia, obstructive sleep apnea, or cardiovascular disease? Yes No If yes, provide details below

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: