Underwriting Questionnaire Gastric Bypass

Producer Name	Phon	ie	Date	
Client Name	Date	of Birth		
Male 🗌 Female	Face Amount	Max Premium \$	5 /yr.	
□Term □Permanent	Has the client ever used any	form of tobacco (cigarettes, c	igars, pipe, snuff, etc.)? 🗌	Yes 🗆 No
Frequency	Date of la	st use	Туре	
Date of procedure	Type of proced	dure (e.g. gastric bypass, banc	ling, etc.)	
Weight prior to procedure_	Current weight	Has weight loss been s	table/maintained 🗌 Yes 🛛	∃No
Height				
Hemorrhage Obstruction	any of the following complication			
Leaks	nction studies			
☐Hypoglycemia				
_	ncies			
5	a			
U	habits/diarrhea due to dietary moc ght			
Problems retaining	g weight			

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:

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