

Underwriting Questionnaire

Osteopenia/Osteoporosis

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 diagnosis _____ Official diagnosis Osteopenia Osteoporosis Mild Severe

Any balance disorder or abnormal gait Yes No If yes, provide details _____

History of falls (details and dates) _____

History of fracture Traumatic Non-Traumatic (details and dates) _____

Date of last DEXA scan _____

T score results: Left hip _____ Right hip _____ Spine _____ Any score worse than -4.0 _____

Any interference with normal activities of daily living (ADLs) Yes No If yes, provide details _____

Regular exercise Yes No If yes, provide details (types of exercises, how often) _____

Any other medical conditions present Yes No If yes, provide details _____

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

Any prescribed medications not being taken _____