Underwriting Questionnaire
Pre-Underwriting

Truist Life Insurance Services

This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

PRODUCER INFORMATION (this section must be completed)

Name	Crump Producer Number
Phone	Email Address
Have you submitted this case previously? ☐ Yes ☐ No	

CLIENT HISTORY (this section must be completed)

Client Name			State	
☐ Male ☐ Female	Date of Birth	Age	Height	Weight
Average weight change in the past 12 months		Occupation		
Is the client a Foreign National? ☐ Yes ☐ No		If yes, list country of citizenship		
Has the client traveled outside the United States? ☐ Yes ☐ No		If yes, list the countries and dates visited		
Green Card? ☐ Yes ☐ No				
Type of Visa				

REQUESTED COVERAGE (this section must be completed)

☐ Universal Life ☐ Survivorship ☐ Variable Life ☐ Whole Life ☐ LTC Rider ☐ Term, Level Period _____

Face amount desired?	If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? _____

Has the case been submitted to other companies in the last 12 months? ☐ Yes ☐ No If Yes, list companies, dates, and action taken

TOBACCO/NICOTINE USAGE USAGE (this section must be completed)

Has your client ever smoked cigarettes:

☐ Yes ☐ No If yes, date of last usage:

Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐ Yes ☐ No

If yes, provide types and last date of use:

MARIJUANA & CBD OIL USAGE (this section must be completed)

Does your client use marijuana ☐ Yes ☐ No If yes, complete the following:

Purpose ☐ Recreational/Social ☐ Medicinal Frequency_____ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Inhaled Date Last Used _____

Does your client use CBD oil? ☐ Yes ☐ No If yes, complete the following:

Frequency_____ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Topical Date Last Used _____

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MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your client's primary care physician? When did your client last consult him/her? Any ongoing medical treatment?			
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below. ☐ Yes ☐ No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

DRUG AND ALCOHOL USAGE ☐ check here if this section is not applicable

Does your client currently drink alcohol? ☐ Yes ☐ No

Type(s) of Alcohol _____

Date of last consumption _____

How much per week _____

Has your client ever drank substantially more than present? ☐ Yes ☐ No

If yes, when? _____

Has your client ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details _____

Has your client ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details _____

Type of drug(s) used _____ Date of last use _____

CORONARY ☐ check here if this section is not applicable

Date of diagnosis or first chest pain	Number of diseased vessels
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)	

Date of last stress EKG	Results	By whom?
Any pain since treatment/surgery?		

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CANCER ☐ check here if this section is not applicable

Exact name and location of cancer	Stage and grade
Who would have the pathology report	Date/details of treatment/surgery

DIABETES ☐ check here if this section is not applicable

Date of diagnosis	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details	
Does your client regularly test his/her blood glucose? ☐ Yes ☐ No	Results		Frequency

Latest result of glycohemoglobin (A1C) test _____mg% Date_____

Has your client been diagnosed with having protein and/or microalbumin in urine? ☐ Yes ☐ No

Have your client ever had: Eye trouble ☐ Yes ☐ No Heart trouble ☐ Yes ☐ No High blood pressure ☐ Yes ☐ No

Have your client ever had: Kidney trouble ☐ Yes ☐ No Neuritis/Neuralgia ☐ Yes ☐ No Insulin reactions ☐ Yes ☐ No

MENTAL DISORDERS/DEPRESSION/ANXIETY ☐ check here if this section is not applicable

Date of diagnosis	Hospitalization ☐ Yes ☐ No	Suicide attemp(s) ☐ Yes ☐ No	Currently employed ☐ Yes ☐ No
Medications			

SLEEP APNEA ☐ check here if this section is not applicable

Date of diagnosis	Is a CPAP used every night ☐ Yes ☐ No	Date of last sleep study
Sleep study results ☐ Mild ☐ Moderate ☐ Severe	Was surgery done ☐ Yes ☐ No	If yes, type of surgery

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Is your client a private pilot? ☐ Yes ☐ No	How many total hours has your client flown as Pilot in Command?_____	How many hours does your client fly per year? _____	Does your client have an IFR (instrument flight rating) ☐ Yes ☐ No

Does your client participate in the following activities? (check those that apply)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving

☐ Mountain Climbing ☐ Hang Gliding ☐ Auto/Motorcycle Racing ☐ Other_____

DRIVING HISTORY ☐ check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Multiple Sclerosis, TIA/CVA, etc.)? If so, please describe below and include additional pages if more space is needed.

Impairment Not Listed	Date of Diagnosis	Treatment Medication(s)	Date of Last Follow-Up Test Results