Underwriting Questionnaire Prescription Underwriting Supplement

Please answer all questions ap	pplicable to the client's medical history.	
Producer Name	Phone	Date
Client Name	Date of Birth	Male 🗌 Female
Face Amount	Max Premium \$ /yr.	Term Permanent
Has the client ever used any fo	orm of tobacco (cigarettes, cigars, pipe, snuff, etc.)?	Yes No
Frequency	Date of last use	Туре
Exact name of medication(s)		
	ed prescription	
Results of recent surveillance to	esting	
Has the client been compliant	with the medication? Yes No	
Has the client has any adverse	effects from the medication? 🗌 Yes 🗌 No	
Has the client been prescribed explain	medication by his/her doctor that he/she has decided t	o discontinue on his/her own? If yes, please

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