Pre-Underwriting

Please answer all questions applicable 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 form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

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

_____

Date of last routine physical _____

Health Conditions	Medications (including over-the-counter)

Height _____ Weight _____ Average weight change is past 12 months _____

Latest blood pressure reading _____ Date _____

Cholesterol/HDL results _____ Date _____

Family history: Has any immediate family member (parents or siblings) had death or disease up to age 65 from cancer, diabetes, cerebrovascular disease, or heart disease? If yes, complete the information below.

Relation (Mother, Father, Brother, Sister)	Type of Disease	If Cancer, Type of Cancer	Age of Onset	Age at Death (If Deceased)

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Check the following and provide details if applicable.

☐ **Alcohol/Drug Abuse**

Current user ☐Yes ☐No Duration used_____ Date stopped using _____

Kind of substance_____ Amount used _____ Type of treatment _____

Attend AA/NA or other programs ☐Yes ☐No Any relapses ☐Yes ☐No

Any motor vehicle violations or DUIs ☐Yes ☐No If yes, provide details _____

☐ **Asthma/COPD**

When diagnosed _____ Number of attacks per year _____

Date and severity of last attack _____ Are attacks seasonal ☐Yes ☐No

Any hospitalizations ☐Yes ☐No If yes, when _____

☐ **Aviation**

Total hours flown as pilot or co-pilot _____ IFR? _____ Hours flown per year _____

Type of license_____ Purpose (civilian, military, etc.)_____

☐ **Cancer**

Type_____ Location_____ Staging_____

Grading or copy of pathology report_____ Any positive lymph nodes ☐Yes ☐No

Depth, level, or Gleason Score_____ Date of surgery_____

Any radiation or chemo ☐Yes ☐No If yes, date treatment ended _____

Any recurrence of cancer ☐Yes ☐No If yes, provide details _____

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☐ **Cardiac Disorders**

Any History Of?	**Date of Onset**	**Treatment Given**
☐ MI (heart attack)	_____	_____
☐ Irregular heart beat	_____	_____
☐ Valve disorder	_____	_____
☐ Coronary artery disease	_____	_____

Date of last cardiologist visit _____ Reason _____

Date of most recent stress test _____ Results _____

Date of most recent echocardiogram _____ Results _____

Ever Have?	**Date**	**Results**	
☐ Coronary catheterization	_____	_____	
☐ Bypass surgery (CABG)	_____	_____	# of vessels _____
☐ Angioplasty (PTCA)	_____	_____	# of vessels _____
☐ Valve surgery or replacement	_____	_____	which valve _____
☐ Stenting	_____	_____	which vessel(s) _____

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☐ **Crohns** ☐ **Colitis**

Date diagnosed_____ Any hospitalizations or surgery ☐Yes ☐No If yes, what_____

_____ _____

☐ **Diabetes**

Date diagnosed_____ Treatment (oral meds, insulin, diet)_____ Units of insulin _____

Names of medications_____

Number of regular doctor visits per year_____

Any complications_____

Last fasting blood sugar and date_____ Last glycohemoglobin (A1c) and date _____

☐ **Foreign Travel/Foreign Residence**

Citizenship_____ Type of Visa_____ Does client have a green card ☐Yes ☐No

Answer the following if the client is not a US citizen

How long in the US_____ Works in the US ☐Yes ☐No Owns property in the US ☐Yes ☐No
US bank account ☐Yes ☐No

Travel outside the US

Country	**City**	**Duration of Stay**	**Frequency**	**Purpose of Travel**

☐ **Hepatitis**

Type ☐A ☐B ☐C Date diagnosed_____ Cause_____

Current status ☐Active ☐Cured Medications/date of last use_____

Current alcohol use/amount_____

☐ **Hypertension**

Date diagnosed_____ Average readings_____ Are readings monitored at home ☐Yes ☐No

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☐ **Lab Abnormalities**

What tests were abnormal _____ Results/date(s) _____

Any diagnosis given _____ How long has test been abnormal _____

☐ **Multiple Sclerosis** ☐ **Lupus**

Date diagnosed _____ Last attack _____ Attack frequency _____

How long do attacks last _____ Any disability _____

☐ **Mental Disorders/Depression/Anxiety**

Diagnosis _____ Date _____

Hospitalization ☐Yes ☐No Suicide attempt(s) ☐Yes ☐No Currently employed ☐Yes ☐No

☐ **Seizure Disorder/Epilepsy**

Date of last seizure _____ Date of diagnosis _____ Type of seizure _____

Frequency of seizures _____

☐ **Sleep Apnea**

Date diagnosed _____ Is 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 _____

☐ **TIA/CVA (transient ischemic attack-ministroke/stroke)**

Date of episode _____ Number of episodes _____ Any residuals _____

Type of treatment/medication _____

☐ **Avocations (scuba, mountain climbing, etc.)**

Specify _____

☐ **Impairments not listed**

Diagnosis given _____ Date _____

Treatment _____ Medications _____

Date of last follow-up _____ Test results _____

Questions?

Call McGill Brokerage at (800)-279-0751 ext. 233 for Dan Dahl, 210 for Tim Simmons, and 228 for Gary Kay. Email questions or completed forms to ddahl@mcgillbrokerage.com, tsimmons@mcgillbrokerage.com, and gkay@mcgillbrokerage.com.

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