

# UNDERWRITING CLASSIFICATION QUESTIONNAIRE

A GUIDE TO CATEGORIZING YOUR CLIENT

MALE  
 FEMALE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

- 1) TOBACCO USE?  YES  NO  
IF NO, # OF YEARS WITH NO TOBACCO USE - \_\_\_\_\_  
IF YES,  CIGARETTES - # PACKS/DAY - \_\_\_\_\_  
 CIGARS - #/DAY/WEEK/MONTH \_\_\_\_\_  
 PIPE - # PIPEFULLS/DAY - \_\_\_\_\_  
 OTHER, SPECIFY \_\_\_\_\_  
AMOUNT/DAY - \_\_\_\_\_

2) HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ WEIGHT 1 YR. AGO: \_\_\_\_\_

- 3) FAMILY HISTORY:  
(A) DOES ANY FAMILY MEMBER (PARENTS OR SIBLINGS), AGE 70 OR YOUNGER, HAVE A HISTORY OF CARDIOVASCULAR DISEASE, CANCER, DIABETES, STROKE, OR FAMILIAL DISEASE?  YES  NO  
(B) HAS ANY FAMILY MEMBER DIED, AT AGE 60 OR YOUNGER, FROM CARDIOVASCULAR DISEASE, CANCER, DIABETES, STROKE, OR FAMILIAL DISEASE?  YES  NO

IF YES, STATE PRESENT AGE, RELATIONSHIP, AND DISEASE ENTITY OR AGE AT DEATH AND DISEASE ENTITY:

RELATIONSHIP	LIVING	DECEASED	CANCER	CARDIOVASCULAR	AGE

4) TOTAL CHOLESTROL READING: \_\_\_\_\_ ON MEDICATION?  YES  NO  
CHOLESTROL/HDL RATIO: \_\_\_\_\_

5) BLOOD PRESSURE READING (AVERAGE): \_\_\_\_\_ ON MEDICATION?  YES  NO  
ANY PREVIOUS BLOOD PRESSURE MEDICATION?  YES  NO

6) ANY HISTORY OF SUBSTANCE ABUSE?  YES  NO  
IF YES, STATE DETAILS: \_\_\_\_\_

7) DRIVING RECORD:  
(A) SPEEDING VIOLATIONS: # \_\_\_\_\_ YEAR(S) INCURRED: \_\_\_\_\_  
(B)  DWI : # \_\_\_\_\_ YEAR(S) INCURRED: \_\_\_\_\_  
 DUI : # \_\_\_\_\_ YEAR(S) INCURRED: \_\_\_\_\_

8) DO YOU FLY AN AIRPLANE?  YES  NO STUDENT PILOT?  YES  NO  
IF YES: A) TOTAL # SOLO HOURS: \_\_\_\_\_  
B) # HOURS/YEAR : \_\_\_\_\_  
C) INSTRUMENT RATING?  YES  NO  
D) TYPE OF AIRCRAFT FLOWN: \_\_\_\_\_

9) HAZARDOUS SPORTS:  
TYPE OF ACTIVITY: \_\_\_\_\_ FREQUENCY \_\_\_\_\_  
(Call for Individual Hazardous Sports Questionnaire)

10.) IF APPLICANT HAS PLANS FOR FUTURE FOREIGN TRAVEL, PLEASE PROVIDE DETAILS.  
\_\_\_\_\_

PLEASE NOTE: IF YOUR APPLICANT HAS ANY SIGNIFICANT MEDICAL IMPAIRMENT, PLEASE CALL OUR OFFICE TO REVIEW THEIR CONDITION WITH OUR STAFF.

