# Pre-Quote Underwriting Questionnaire

NAME ☐ DATE OF BIRTH ☐ MALE ☐ FEMALE ☐ STATE ☐

HEIGHT ☐ WEIGHT ☐ BLOOD PRESSURE ☐ TOTAL CHOLESTEROL ☐ CHOL RATIO ☐

TOBACCO USE HISTORY - Check all that apply: ☐ No tobacco or nicotine use in the last 5 years or more

☐ No tobacco or nicotine use in the last 3 years ☐ No tobacco or nicotine use in the last year

TYPE OF USE - Check all that apply: ☐ Cigarettes ☐ E-cigs or Vaping ☐ Chewing Tobacco or Snuff

☐ Pipe ☐ Nicotene Gum or Pouches ☐ Cigars - please indicate average number of uses per year ☐

ANY MARIJUANA OR CANNIBAS PRODUCTS USED IN THE LAST 5 YEARS? ☐ Yes ☐ No If yes, complete form below.

PLEASE LIST ALL MEDICATIONS PRESCRIBED IN THE LAST 2 YEARS. Include the reason and approximate date prescribed.

HAS A PARENT OF ANY SIBLINGS HAD ANY HISTORY OF CANCER, STROKE, DIABETES, OR HEART DISEASE BEFORE AGE 70?

☐ Yes ☐ No If yes, please specify type of condition, age on onset, age of death, and if it was the cause of death.

ARE YOU A STUDENT OR PRIVATE PILOT OR DO YOU ENGAGE IN ANY EXTREME OR HAZARDOUS AVOCATION LIKE SKY DIVING, HANG GLIDING, SCUBA DIVING, MOTOR RACING, ROCK CLIMBING, HELI-SKING, OR OTHERS? ☐ Yes ☐ No

If yes, please provide details of these activities including frequency.

ANY MOVING VIOLATIONS OR DUIs IN THE LAST 5 YEARS? ☐ Yes ☐ No If yes, please provide date and type.

PLEASE PROVIDE DETAILS OF ANY FOREIGN TRAVEL IN THE LAST 2 YEARS OR PLANNED FOR THE NEXT 2 YEARS.

Please provide details of any history of the following conditions. Include the name of the condition, approximate age of onset, treatment, and the current status. *Asthma, anxiety, cancer of any kind (other than basil cell carcinoma), depression, alcohol or drug abuse or addiction, sleep apnea, heart condition of any kind, stroke, TIA, diabetes, glucose intolerance, gout, arthritis, any auto-immune condition, anemia or any blood disorder, hepatitis, high cholesterol, high blood pressure, or any other chronic or on-going disease or disorder.*

# Marijuana Use Questionnaire

***Complete only if any marijuana or cannibas use in the last five years***

Approximately when was the last time you used a cannabis product? ☐

How many times, on average, do you use cannabis products each month? ☐

If less than once per month, how many times in the last year? ☐

If none in the last year, how many times in the last 5 years? ☐

Is your use recreational or by prescription? ☐ Recreational ☐ Prescription

If prescription, what condition is it treating? ☐

What type of cannabis products do you use? ☐ Edibles ☐ Pipe ☐ Vape ☐ Smoke

If you smoke, do you blend it with tobacco? ☐ Yes ☐ No

Do you use any other drugs not obtained by prescription? ☐ Yes ☐ No

If yes, what type of drugs and what is the frequency of use?

☐

Do you have any history of drug or alcohol addiction or treatment? ☐ Yes ☐ No

If yes, please provide details including dates, type, and outcome.

☐

Has a physician ever advised you to discontinue or reduce your use of alcohol? ☐ Yes ☐ No

If yes, please provide date, details, and result.

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