GBS Insurance and Financial Services
A Gallagher Company

FIELD UNDERWRITING QUESTIONNAIRE

Please answer all health questions that you can. The more questions that are answered, the more accurate the underwriting determination. Any questions not answered will be ignored when determining the underwriting class.

Date: _____

PERSONAL INFORMATION

Client Name: First	Middle Initial	Last	Date of Birth
		☐ Male ☐ Female	

Phone:	Fax:	E-mail:
State of Residence:	Occupation:	
Height ft. in.	Weight lbs.	

TOBACCO USAGE

Have you ever used nicotine-based products? (Check one)

☐ Never ☐ Currently Use ☐ None in the past 12 months ☐ None in the past 2 years
☐ None in the past 3 years ☐ None in the past 4 years ☐ None in the past 5 years

Which types of tobacco/nicotine products have you used? (Check one)

☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew/Dip ☐ Snuff ☐ Nicotine/Patch/Gum/Pill ☐ Vapor

How many cigarettes do you smoke per day?

How many cigars do you smoke per year?

How many times do you smoke a pipe per year?

Will you test negative for Nicotine? ☐ Yes ☑ No

Do you use medical marijuana? ☐ Yes ☐ No

BLOOD PRESSURE

What is your Systolic blood pressure level?

What is your Diastolic blood pressure level?

Are you taking any blood pressure medication? ☐ Yes ☐ No

CHOLESTEROL LEVEL

What is your cholesterol total level?

What is your HDL level?

Are you taking any cholesterol medication? ☐ Yes ☐ No

FAMILY HISTORY

Have you had family members (parent or siblings) diagnosed with Cancer, prior to age 70? ☐ Yes ☐ No

Did death occur due to Cancer? ☐ Yes ☐ No **If Yes, what was the age at death?** _____

Relationship	Age of Onset	Diagnosis

Have you had family members (parent or siblings) diagnosed with Cardiovascular Disease, prior to age 70? ☐ Yes ☐ No

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Did death occur due to Cardiovascular Disease? ☐ Yes ☐ No **If Yes, what was the age at death?** _____

Relationship	Age of Onset	Diagnosis

MEDICAL HISTORY

Please check any medical conditions(s), for which you have been diagnosed:

☐ Alcohol/Drug Abuse or Dependency	☐ Melanoma
☐ Asthma	☐ Mental/Emotional Disorders
☐ Cancer	☐ Multiple Sclerosis
☐ Cardiovascular/Heart Disease	☐ Rheumatoid Arthritis
☐ Chronic Obstructive Pulmonary Disease	☐ Sleep Apnea
☐ Coronary Artery Disease	☐ Stroke
☐ Crohn's Disease	☐ Ulcerative Colitis
☐ Depression/Anxiety	☐ Vascular Disease
☐ Diabetes	☐ Epilepsy/Convulsions
☐ Gastric/Peptic Ulcers	☐ Heart Attack
☐ Hepatitis	☐ Kidney or Liver Disease
☐ Lupus	

DRIVING RECORD

Have you had any moving violations or reckless driving convictions? ☐ Yes ☐ No

If yes, when? Month / Year

Has your license ever been suspended or revoked? ☐ Yes ☐ No

If yes, when? Month / Year

ALCOHOL/SUBSTANCE ABUSE

Do you have a history of, or have you ever been treated for alcohol or substance abuse? ☐ Yes ☐ No

If yes, how many years ago?

Did you require treatment? ☐ Yes ☐ No

FOREIGN TRAVEL

Have you or do you plan on traveling outside the United States for either business or pleasure? ☐ Yes ☐ No

If yes, what countries?

HAZARDOUS SPORTS/AVOCATION/AVIATION

Have you participated in any of the following?

☐ Automobile or Motorcycle Racing	☐ Mountain Climbing
☐ Bungee Jumping	☐ Piloting an Aircraft
☐ Sky Diving/Aerial Sports	☐ Other: _____
☐ Scuba Diving	