CAPITAS® FINANCIAL, INC.

Life Insurance - Medical Questionnaire

Please thoroughly complete this form. In order to provide an accurate quote we need specific detail. This information is the first step in the risk assessment and quoting process.

Client Name: _____ Date of Birth: _____/_____/_____

Have you ever used tobacco or nicotine products?

- o **No**: _____
- o **Current type use**:

  ☐ Pipe ■ Cigar ☐ Chewing Tobacco ☐ Cigarettes ☐ Patch ☐ Nicotine Gum Qty: _____

- o **Past use** (not currently using): Type: _____ Date stopped: _____/_____/_____

Gender: _____ Height: _____ Weight: _____

Any weight loss over 10 pounds in the past 12 months? If yes, how many pounds? _____

State application will be signed in: _____

Face Amount: _____

Length of Term: ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ Other: _____

Rider Choices: **Child**: $_____,000 **DI**: ☐ Yes ☐ No **LTC Alternative**: ☐ Yes ☐ No

Current Life coverage (amount, carrier): _____

Has the client ever applied for and not taken Life Insurance (carrier, year, rating or decline):

_____

Annual income: _____ Occupation & Job Duties: _____

Is the potential insured collecting social security disability benefits? ☐ Yes ☐ No

Date started disability: _____/_____/_____ Reason: _____

Expected length of time: _____

Please list **all** medical conditions or other issues not addressed on the questionnaire (ex. pregnancy, rheumatoid arthritis, etc.). Provide as many details as possible (ex. due date, date of diagnosis, complications, etc.):

_____

_____

_____

Key Questions

Please thoroughly complete this form. In order to provide an accurate quote we need as much detail as possible. This information is the first step in the assessment and quoting process.

Have you been to the doctor or hospital in the past 5 years?

Name of doctor , contact information	When?	Reason for visit?
Name of doctor , contact information	When?	Reason for visit?
Name of doctor , contact information	When?	Reason for visit?

Have you been referred for follow up (to a doctor or for testing) that you have not completed yet? If so, please give details: _____

_____

Please list any medications taken in the past 12 months (even those not currently taking):

Name of medication	Dosage	Taken for how long	Frequency	Reason Prescribed
Name of medication	Dosage	Taken for how long	Frequency	Reason Prescribed
Name of medication	Dosage	Taken for how long	Frequency	Reason Prescribed
Name of medication	Dosage	Taken for how long	Frequency	Reason Prescribed

Have you ever had any motor vehicle tickets or fines in the past 5 years (including DUIs)?

Infraction	Date
Infraction	Date
Infraction	Date

1. Have you had any parents or siblings with a history of (please indicate whether diagnosis/death):

   Diabetes: Diagnosis Age _____ Death Age _____ ☐ Mother ☐ Father ☐ Sibling

   Cancer: Diagnosis Age _____ Death Age _____ ☐ Mother ☐ Father ☐ Sibling

   Heart Issues: Diagnosis Age _____ Death Age _____ ☐ Mother ☐ Father ☐ Sibling

2. Please note any past or documented future foreign travel (Dates, Location, Length of Stay, Frequency, Purpose)?

   _____

3. Do you engage in any risky activities (scuba diving, flying, parachuting, racing, etc.)? Provide relevant details that help assess risk (Type of activity, Frequency, Amount of time annually, Depth, Height, Type of equipment, Lifetime hours with activity):

   _____

Additional Information for Specific Medical Conditions

Drug and Alcohol Treatment

Date: ____/____/_____ Length of Stay _____ ☐ Court Ordered OR ☐ Voluntary

Drugs (Names and frequency): _____ Date of last use: ____/____/_____

Alcohol (Type and frequency): _____ Date of last use: ____/____/_____

Participation in a support group (ex. AA): _____ ☐ Active OR ☐ Past

Asthma

Date of diagnosis: ____/____/_____ Age at diagnosis: _____

Type: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced

Inhaler use: ☐ Yes ☐ No (**provide details on page 2 in medication section**)

Results of pulmonary function tests (FVC and FEV1): _____

Frequency of attacks: _____ Dates of first / most recent attacks: _____

Any hospitalization or ER visits? _____ Date of most recent visit: ____/____/_____

Coronary Artery Disease

Date of Occurrence: ____/____/_____ Heart Attack? : _____ Damage? : ☐ Yes ☐ No

☐ Bypass ☐ Stent ☐ Angioplasty – how many vessels: _____ Which part of the heart: _____

When were the last comprehensive coronary exams/tests (Date, type of test, follow-up):

_____

Were the results: ☐ Normal OR ☐ Abnormal Ejection Fraction: _____

Cancer – for accuracy, attach a copy of all post surgical pathology reports

Type and location: _____ Date of diagnosis: ____/____/_____

Size: _____ Stage: _____ Grade: _____

Treatment (surgery/chemo): _____

Diabetes

Age diagnosed: _____ Current A1C reading: _____

Any complications or residual effects: _____

Depression / Anxiety

Date of diagnosis: ____/____/_____ Type of treatment: ☐ Medication ☐ Therapy ☐ Both

Dates of any hospitalization: _____ Dates of any suicidal thoughts/attempts: _____

Any missed work/inability to perform functions of daily living: _____

Sleep Apnea

Date of diagnosis: ____/____/_____ Type of treatment: _____

Type: ☐ Obstructive ☐ Central Date of last sleep study: ____/____/_____

Respiratory disturbance index (RDI): ☐ Mild (RDI 5-15) ☐ Moderate (RDI 16-30) ☐ Severe (RDI +30)

Pain Medication Use

Injury type: _____ Treatment: ☐ Therapy ☐ Surgery ☐ None

Date started pain medication: ____/____/_____ (provide details on page 2 in medication section)

Currently using pain medication: ☐ Yes ☐ No

What positive lifestyle activities do you perform? Please check all that apply: ☐ Drink in moderation

☐ College Degree ☐ Annual check-up ☐ Life-time non-smoker ☐ Regular exercise