



Questionnaire Kit

Often the most difficult part of the sales process can be obtaining and understanding the risk factors that make your client eligible (or not eligible) for insurance. This kit has been developed as a resource to assist you in the field underwriting process. With your detailed fact-finding of your client's health and lifestyle, we are better positioned to match the proper carrier and product to your client's needs.

Included here are questionnaires to help you talk to your clients about some of the most common medical and non-medical risks that can affect the underwriting process, and ultimately the pricing on a new policy:



General Health
Alcohol & Drug
Aviation
Avocation
Cancer
Cardiac
Diabetes
Foreign Travel & Residence
Tobacco

Many of our conversations with brokers begin with *"I gotta guy who has... what can you do for him?"*

Our job is to help bridge the gap between the challenge and the solution so that you can be free to do what you do best: SELL! After all, you should be in business for yourself, not by yourself!

**I
GOTTA
GUY...**

**Faxed or emailed copies are acceptable.
Originals are not required.**



These forms are for pre-sale purposes only. Insurance carriers will require their specific questionnaires to be completed and signed by your client when a formal application is submitted.



LARRY GORDON AGENCY, INC.

www.lganet.com

Chicago - Milwaukee - Rockford

Alcohol/Drug Questionnaire

Broker Name: _____

1. Name of Proposed Insured: _____ Date of Birth: _____

2. Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.

3. Have you ever used tobacco? Yes No Date Last Used: _____ Type: _____

4. Do you presently use alcoholic beverages? Yes No

If "Yes", please advise:

Frequency: (Daily/Weekly) _____

Type: (Beer/Wine/Liquor) _____

Number of Drinks: (or ounces) _____

5. Have you ever consumed more alcohol than at present? Yes No

If "Yes", please advise, when:

Frequency: (Daily/Weekly) _____

Type: (Beer/Wine/Liquor) _____

Number of Drinks: (or ounces) _____

6. Why did you change your drinking habits? _____

7. Have you ever used Amphetamines, Barbituates, Cocaine, Heroin, Crack, Marijuana, LSD, PCP, or other illegal restricted or controlled substances, except as prescribed by a licensed physician? Yes No

If "Yes", please provide date of use: From: _____ To: _____

Name of drug used: _____

Amount and frequency of use: _____

8. Have you ever had employment/financial/family problems as a result of your alcohol/drug use? Yes No

If "Yes", please provide complete details: _____

9. Have you ever been charged with driving under the influence or had any other traffic violation(s) and/or accident(s) where alcohol or drug use was involved? Yes No

If "Yes", please provide complete details: _____

10. Have you ever consulted a physician, received treatment or advice, or been hospitalized because of your alcohol and/or drug use? Yes No

If "Yes", please provide date, hospital or treatment center, and Physician's names and addresses:

11. Have you ever participated in a self-help group, such as Alcoholics or Narcotics Anonymous? Yes No

If "Yes", please provide name of self-help group: _____

How frequently did you attend? _____

12. Please provide any additional information you feel would help us in evaluating your application: _____



LARRY GORDON AGENCY, INC.

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Aviation Questionnaire

Broker Name: _____

Proposed Insured: _____

Date of Birth: _____

1. Indicate flying experience: Non-Commercial Commercial Military Pilot Crew Member Other
2. Current type of aviation certificate: _____
3. Has your certificate ever been suspended or revoked? Yes No If Yes, give details in Remarks.
4. Current class of medical certificate and expiration date: _____
5. Total hours flown as a pilot in command: _____
6. Do you have an Instrument Flight Rating (IFR)? Yes No Number of hours of IFR flying: _____
7. Do you fly outside the US? Yes No If Yes, give details in Remarks.
8. Have you had any aviation accidents/citations? Yes No If Yes, give details in Remarks.
9. Indicate number of hours flown in each category as a pilot, student pilot, or crew member:

	Type of Flying	Last 12 Months	Last 12-24 Months	Next 12 Months	Date of Last Flight
Non-Commercial					
	Student				
	Pleasure or Business				
	Other (Racing, Acrobatics, Stunt, etc. Describe in Remarks)				
Commercial					
	Scheduled Passenger Airline (Give employer in Remarks)				
	Non-Scheduled Passenger and/or Freight Airline				
	Flight Instruction				
	Corporate Owned Planes for Corporate Business				
	Testing (Describe type of testing and aircraft in Remarks.)				
	Crop-Dusting				
	Fire Fighting				
	Other (Describe type in Remarks.)				
Military					
	Active Duty				
	Reserve Duty				

10. Indicate total hours flown by aircraft type:

Civilian	Single Engine Airplane	Multi Engine Airplane	Helicopter	Home Built	Other
Hours flown in Past 12 Months					
Hours flown in Next 12 Months					

Military	Transport MAC	Fighter Bomber	Helicopter	Carrier Based	Proficiency Flying Only	Other
Hours flown in Past 12 Months						
Hours flown in Next 12 Months						

11. If an aviation extra premium is required do you prefer: Aviation Coverage or Aviation Exclusion Rider?

Remarks: _____



Broker Name: _____

- 1. Name of Proposed Insured: _____ Date of Birth: _____
- 2. Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.
- 3. Have you ever used tobacco? Yes No Date Last Used: _____ Type: _____

Scuba Diving

- 4. Type or purpose of Diving: Recreation Instruction Construction Salvage Search Work
 Cave Diving Other _____
- 5. Location in which you dive: Deep Sea / Ocean Other (lake, cave, etc.) _____
- 6. Type of certification held _____ Date of certification _____ Equipment used _____
- 7. Do you ever dive alone? Yes No
- 8. Diving activity: (Select "usual depth" to which proposed insured dives.)

Past 12 months			Past 12-24 months		Contemplated next 12 months	
Depth of dives	# of dives	Avg time per dive	# of dives	Avg time per dive	# of dives	Avg time per dive
0-75 feet						
76-100 feet						
101-150 feet						
Over 150 feet						

Organized Racing - Automobile, Boat, Motorcycle, Snowmobile

- 9. Status: Professional Amateur Other _____
- 10. Do you hold a competition driver's license from any organization? Yes No
If "yes", list all organizations _____
- 11. Type of racing: Stock car Sport car Sprint car Championship Formula car Midget Drag
 All-terrain Motorcycle Powerboat Snowmobile Other _____
- 12. Vehicle: Make _____ Model _____ Horsepower _____ Engine displacement (cc) _____
- 13. Course type: a) Paved track Hill Climbing Desert/Off Road Drag Strip Road Course
 Dirt track Cross-Country Other _____
b) Length of course _____ c) Length of race _____ d) Average speed _____
e) Max speed attained (mph) _____
- 14. Number of races: a) Last 12 months _____ b) Last 12-24 months _____ c) Next 12 months _____

Parachuting Skydiving Hang Gliding

- 15. Status: Professional Amateur Other _____
- 16. Do you belong to an organized club? Yes No If "yes", name of club _____
- 17. Number of jumps: a) Last 12 mo. _____ b) Last 12-24 mo. _____ c) Next 12 mo. _____ d) Total to date _____
- 18. Type of jumps (stunting, instructional, BASE, or any form of parachuting that does not involve an aircraft) _____
- 19. Over what type of terrain are jumps made? (Aerial stunts over land, cliff jumping over water, etc.) _____

Mountain Climbing Rock Climbing

- 20. Type of climbing: Trail Ice Rock Glacier Snow
- 21. Type of training _____ Years of experience _____
- 22. Do you belong to an organization? Yes No If "yes", name of organization _____
- 23. Equipment used _____
- 24. Number of climbs: a) Last 12 mo. _____ b) Last 12-24 mo. _____ c) Next 12 mo. _____ d) Total to date _____
e) Climbing details:

Date	Type (mountain, rock, ice, etc.)	Level or Class (A1-A5, 1-6, etc.)	Elevation (ft / mtrs)	Location (Mountain range/State/Country)

Other Avocation Activities Please provide details regarding any other avocation activities in which you participate:



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Cancer Questionnaire

Broker Name: _____

1. Name of Proposed Insured: _____ Date of Birth: _____

2. Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.

3. Have you ever used tobacco? Yes No Date Last Used: _____ Type: _____

4. Please note type of cancer diagnosed: _____

5. List date of first diagnosis: _____

6. How was the cancer treated? (check all that apply)

- Surgery Date: _____
- Radiation therapy Date: _____
- Immunotherapy Date: _____
- Chemotherapy Date: _____
- Hormonal therapy Date: _____

7. Please list stage and grade of the cancer: _____

8. Are you on any medications? Yes No

If "Yes", please give name, dosage, and frequency: _____

9. Has there been any evidence of recurrence? Yes No

If "Yes", please give details: _____

10. Do you have any other major health problems (ex: heart disease, etc.)? Yes No

If "Yes", please give details: _____

11. Is there a history of cancer among your parents, brothers or sisters? Yes No

	Age(s) if Living	Health	Age(s) at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				



Broker Name: _____

- Name of Proposed Insured: _____ Date of Birth: _____
- Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.
- Have you ever used tobacco? Yes No Date Last Used: _____ Type: _____
- Name, address, and date of last consult of cardiologist or other doctor seen most recently for your heart condition: _____

- a) Have you or have you been told you have angina pectoris (chest pain)? Yes No

Date of Most Recent Symptoms	Name of Hospital	Name and Address of Doctor Consulted

- b) Have you been told you had a myocardial infarction (heart attack)? Yes No

Date(s) of Heart Attack(s)	Name of Hospital	Name and Address of Doctor Consulted

- How often do you have heart symptoms (chest, arm or neck discomfort, sense of chest pressure, etc.)? Frequency _____
- a) Date of MOST RECENT cardiac stress test _____ b) What were the results? Normal Abnormal
c) What doctor or clinic has the results (if different than above)? _____

- Have you had or been advised to have:

	Yes	No	Date	Name and Location of Hospital
Cardiac catheterization (coronary angiography)				
Coronary angioplasty (PTCA)				
Coronary artery bypass surgery				

If "Yes," please provide which artery or vessel, location and extent of blockage? _____

- How long were you out of work due to conditions in No. 5 and No. 8 above? _____
- Are you taking any medication? Yes No

Medication Name (Copy from Pharmacy label)	Date Last Taken	Dosage/Frequency

- Do you carry nitroglycerin for chest discomfort? Yes No If "Yes," date last used _____

- What are your average blood pressure readings _____

- a) Do you engage in regular exercise other than that occurring during your work? Yes No

Type of Exercise	Number of Times/Week	Number of Minutes Each Time

- b) How long have you been exercising as above? _____

- c) Is this part of a prescribed cardiac rehabilitation program? Yes No

- Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers or sisters? Yes No

	Age(s) if Living	Health	Age(s) at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

- Do you have any other major medical impairments? Yes No (If "Yes," please provide details on back.)



1. Name of Proposed Insured: _____ Date of Birth: _____

2. Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.

3. Have you ever used tobacco? Yes No Date Last Used: _____ Type: _____

4. When were you first diagnosed with diabetes? Date: _____

5. Name and address of physician: _____

6. Are you receiving treatment or are you under supervision now? Yes No
If "Yes", date of last visit: _____ Name and address of physician (if different from above): _____

7. How are you treating your diabetes?
 Diet only
 Insulin: Units _____ (per day) Insulin Pump Yes No
 Oral medication: Name and dosage _____

8. Do you regularly do home glucose monitoring? Yes No
Average range at home? _____

9. When was your last glycohemoglobin (Hemoglobin A1C) test? _____ Result? _____
Who performed the test? (Full name and address, if different from above) _____

10. (a) Have you ever been in (ketoacidosis) diabetic coma? Yes No
Number of times: _____ Dates: _____

(b) Have you ever had insulin shock (hypoglycemia)? Yes No
Number of times: _____ Dates: _____

(c) If 10(a) and/or 10(b) is answered "Yes," please advise the names and the physicians seen and the hospitals used for the most recent episodes of each: _____

11. Have you ever had or been told you had any of the following? (Please indicate "Yes" or "No")

Changes in vision or retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye laser therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Albumin or protein in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please provide details to any "Yes" answers, including names of physicians and dates: _____

12. Have you ever had an abnormal electrocardiogram (EKG) or stress test? Yes No
If "Yes" please provide date and by whom: _____



Name of Proposed Insured: _____ Date of Birth: _____

A. CITIZENSHIP

- 1. Are you a citizen of the U.S. by birth? Yes No
If yes, go to Section D
- 2. Are you a Naturalized citizen of the U. S.? Yes No
If yes, go to Section B
- 3. Are you a citizen of a country other than the U.S.? Yes No
If yes, go to Section C

B. U.S. CITIZEN (NATURALIZED)

- 1. Where were you born? _____
- 2. What is your naturalization number? _____
- 3. How long have you lived in the U.S.? _____
- 4. When do you plan to return to your native country (duration & expected frequency)?

- 5. Complete Section D.

C. NON-U.S. CITIZEN

- 1. Of what country are you now a citizen?
- 2. Indicate type of visa:
 - Permanent Visa (Give Alien Registration # _____)
 - Temporary Visa (Give Expiration Date _____)
- 3. Indicate purpose of visa (work, student, government employee, etc.): _____
- 4. Have you applied for U.S. citizenship? Yes No
- 5. Do you also maintain a foreign residence? Yes No
If so, what is the address? _____
- 6. Where does your immediate family (spouse & children) reside? _____
- 7. When do you plan to return to your native country (duration and expected frequency)?

- 8. How long have you lived in the U.S.? _____
- 9. Complete Section D.

D. FOREIGN TRAVEL or RESIDENCE

City	Country	Purpose (Give full details)	Date	Length of Stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

City	Country	Purpose (Give full details)	Date	Length of Stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- 3. Indicate the type of environment (Metropolitan, Rural/Agricultural, Primitive/Native, etc.):

- 4. Comments: _____



Broker Name: _____

Name _____ Sex _____ Date of birth _____

Amount \$ _____ Term / UL / WL Height / Weight _____

Have you ever used tobacco? Yes No

Date last used _____ Type _____

Frequency _____

Illness Have you been diagnosed with or treated for:

- Chest pain or any disorder of the heart or blood vessels
- Cancer, Tumor, Leukemia, Melanoma or Lymphoma
- Any disorder of the brain or nervous system
- Any other surgeries or diagnosis not mentioned above
- Mental or psychiatric illness
- Diabetes or high blood sugar
- Disorder of kidneys or urinary tract
- Asthma or any disorder of the lungs
- High blood pressure
- High cholesterol
- Sleep Apnea

If your response is "yes" to any of these questions, please provide additional information below or on back page:

Illness/Date of Diagnosis	Treatment/Medication/Dosage	Date of Treatment	Name and Address of Doctor/Hospital

Lifestyle Have you:

- Used or are you now using cocaine, amphetamines, marijuana, heroin, or other drugs?
- Had or been advised to have treatment or counseling for alcohol?
- In the last 3 years had a driver's license denied, suspended, or revoked, been convicted of or cited for 3 or more moving violations or a DUI, or been involved as a driver in 2 or more auto accidents?
- Been convicted of or are you currently charged with a criminal offense?
- Been or are you currently a member of the armed forces including reserves?
- Any plans to live or travel outside the United States or Canada within the next 12 months?
- Participated in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions, Scuba diving, mountain climbing, parachuting, skydiving or any other such sport or hobby?

If your response is "yes" to any of these questions, please provide additional information below or on back page:

Family History Have any of your immediate family members prior to age 65, died of or been diagnosed as having cancer, coronary artery disease, stroke, or kidney disease?

Relative	Age if Living	Age at Death	Details of Present Health or Cause of Death
Father			
Mother			
Brothers			
Sisters			



1. Name of Proposed Insured: _____ Date of Birth: _____

2. Height: _____ ft. _____ in. Weight: _____ lbs. Weight two years ago: _____ lbs.

Describe your use of tobacco or nicotine products in any form by providing the following information:

3. Do you currently use:

- a. Cigarettes..... Yes No
If "Yes", Number of packs of cigarettes per day _____
- b. Cigars..... Yes No
If "Yes", Number of cigars a day _____
- c. Pipe..... Yes No
- d. Chewing Tobacco..... Yes No
- e. Nicotine Gum..... Yes No
- f. Nicotine Patches..... Yes No

4. Have you ever used:

- a. Cigarettes..... Yes No
If "Yes", month and year last used _____
- b. Cigars..... Yes No
If "Yes" month and year last used _____
- c. Pipe..... Yes No
If "Yes", month and year last used _____
- d. Chewing Tobacco..... Yes No
If "Yes", month and year last used _____
- e. Nicotine Gum..... Yes No
If "Yes", month and year last used _____
- f. Nicotine Patches..... Yes No
If "Yes", month and year last used _____