



The Field Underwriter

Agent Name: _____

Phone: _____

Fax: _____

Email: _____

Client Info

State: _____

Age/DOB: _____

Sex:

Male _____ Female _____

Height: _____

Weight: _____

Face Amount: _____

Insurance Plan Type: _____

Tobacco Use: (check one)

No Tobacco Ever _____ Cigarettes _____ Other _____

Previous Use _____

Please give details of tobacco use, if any

Date of Last Use:

Do you have details on a specific impairment? If so, select the impairment and fill out the details.

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Impairment | <input type="checkbox"/> Lipid Levels |
| <input type="checkbox"/> Aortic Valve Disorders | <input type="checkbox"/> Liver Enzymes |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Bundle Branch Block | <input type="checkbox"/> Pacemakers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Proteinuria |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Chronic Lymphocytic Leukemia | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Colorectal Cancer | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Drug Usage | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Valvular Heart Surgery |
| <input type="checkbox"/> Irregular Heart Beat | |

Nature of Impairment:

1: _____
2: _____
3: _____
4: _____

Date of Diagnosis:

1: _____
2: _____
3: _____
4: _____

Current Status:

1: _____
2: _____
3: _____
4: _____

Nature of Treatment:

1: _____
2: _____
3: _____
4: _____

Any Other Considerations:

