

BUILD QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
 Face Amount: _____ Max. Premium: \$ _____/year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

(1) History of weight:

Height: _____

Highest weight ever: _____
 Date: _____

	Weight	Cause for gain or loss, if known
Current		
3 Months Ago		
6 Months Ago		
1 Year Ago		
2 Years Ago		
5 Years Ago		
10 Years Ago		

(2) Family history:

	Age (if living)	Age at death	Cause of death if deceased:	History of heart disease or circulatory disorder?	History of cancer (all types)?
Mother				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sister(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brother(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(3) Are any medications taken for any reason?

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) What is the proposed insured's blood pressure?

Date:			
Systolic/Diastolic			

(5) What is the proposed insured's cholesterol? LDL ("bad" cholesterol): _____ HDL ("good" cholesterol): _____

(6) Does the proposed insured have any other medical conditions, such as diabetes or heart disease? If yes, please list:

HIGH BLOOD PRESSURE (HYPERTENSION) QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
 Face Amount: _____ Max. Premium: \$ _____/year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

(1) Please provide date of diagnosis: _____

(2) Please provide approximate dates and readings of known blood pressure measurements:

Approximate date(s):	Systolic/Diastolic reading(s):	Approximate date(s):	Systolic/Diastolic reading(s):

(3) Does the proposed insured take any medications to control the blood pressure or for any other reason?

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) Is there any family history of heart disease, circular disorder, or stroke?

	Age (if living)	Age at death	Cause of death if de- ceased:	History of heart disease or circulatory disorder?	History of stroke?
Mother				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sister(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brother(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(5) Does the proposed insured have a history of the following (if yes, check and describe in item six below):

- Elevated cholesterol Diabetes Kidney Disease Heart disease Being overweight
 Stroke TIA Aneurism Prerepheral vascular disease

(6) Please advise of any additional information that may help us provide you with a more accurate preliminary assessment:
