HANSEN Brokerage Services
Added value with a different approach

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Pre-Screening Questionnaire

Proposed Insured: (full name) _____ **Agent Name: _____**

Policy type: _____ **Face Amount: _____**

Date of Birth: _____ Height: _____ Weight: _____ Nicotine Use: Y/N Type/Date Used:_____ Frequency:_____

Please give complete details of all YES answers to questions, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed. **If additional space is required, please use the back of this form**.

Have you ever had, been told by a member of the medical profession that you have, or been diagnosed with or treated for:		**Details:**
1. High blood pressure, heart attack, heart murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	□Yes □No	
2. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	□Yes □No	
3. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	□Yes □No	
4. Cancer, tumor, polyp or cyst? (**If yes, please provide details**)	□Yes □No	
5. Any physical deformity or amputation?	□Yes □No	
6. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	□Yes □No	
7. Any immune deficiency disorder, AIDS, AIDS related Complex (ARC), HIV, or tested positive on an AIDS/HIV-related test?	□Yes □No	
8. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs, or other substance or joined an organization for alcohol or drug dependence or abuse?	□Yes □No	
9. A. Any moving violations? B. Driving under the influence or driving while intoxicated, etc. in the past 10 years? (**If yes, please include dates and violations)**	□Yes □No □Yes □No	
10. Have your parents, brothers, or sisters ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	□Yes □No	
11. Has any application for life, health, disability, or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	□Yes □No	
12. Are you currently taking any prescriptions, vitamins, supplements or over the counter medications? (**If Yes, please list under details**)	□Yes □No	
13. Are you going to be traveling outside of the United States in the next 2 years, business or pleasure? **(If yes, advise destination(s), duration of stay, and purpose of travel**)	□Yes □No	
14. Do you participate in any extreme sports? Underwater diving, Aerial Sports, Motor Sports **(If yes, please provide details)**	□Yes □No	
15. Are you a private pilot? **(If yes, what type of plane, how many hours flown per year and total to date, what certifications do you hold)**	□Yes □No	

Family History:

	Age if Living	**Present Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers #				
Sisters #				