HANSEN
Brokerage Services
YOUR WEALTH PROTECTION TEAM

Please remit completed questionnaire to:
Quotes@HansenBrokerage.com or
Fax: (616)940-4033

Client Full Name: _____ Date of Birth: _____ Height/Weight: _____ Gender: _____

Agent Name: _____ Policy type: _____ Face Amount: _____

Please give complete details of all "yes" answers, 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.

Lifestyle Questions		Details to "yes" answers:
1. Do you currently use, or have you used in the past five years: chewing tobacco, nicotine pouch, gum, patch, lozenges, vape, cigarettes or cigars? If so, please provide the type and frequency of use (include times per week/month/year and date of last use).	YES NO	
2. Have you used marijuana/THC in any form (smoke, vape, edible/gummies) in the past 12 months? If so, please provide the type and frequency of use (include times per week/month/year and date of last use).	YES NO	
3. Have you ever been treated/counseled or advised to seek treatment/counseling for the use of alcohol, drugs or other substances?	YES NO	
4. Have you had any moving violations? If so, provide dates and violations.	YES NO	
5. Have you had any driving under the influence or driving while intoxicated charges (includes both automobile and/or boating)? If so, provide dates and violations.	YES NO	
6. Do you participate in any extreme sports (underwater diving, aerial sports, motor sports) and/or are you a private pilot?	YES NO	
7. Are you traveling outside the USA in the next two years for either business or pleasure? If so, provide the destination, duration of stay and purpose of travel.	YES NO	
8. Has any life/health/disability/LTC application been declined, withdrawn, postponed, rated, issued with exclusions, cancelled or non-renewed?	YES NO	
Have you ever had or been told by a member of the medical profession that you have, or been diagnosed with or treated for:		
9. High blood pressure, heart attack, heart murmur, palpitations, or anemia or any disease or abnormality of the heart, blood vessels or blood?	YES NO	
10. Asthma, chronic bronchitis, sleep apnea, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	YES NO	
11. Diabetes or any disease/abnormality of the thyroid, adrenal, pituitary or other glands?	YES NO	
12. Any form of cancer, tumor, polyp or cysts?	YES NO	
13. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	YES NO	
14. Have your parents and/or siblings ever had cancer, diabetes or heart disease?	YES NO	
15. Please list **all** prescriptions, vitamins, supplements or over the counter medications you are taking.	Use "Details" column to list medications.	

FAMILY HISTORY:	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers #				
Sisters #				