INSURANCE UNDERWRITING QUESTIONNAIRE

The DFS Group LLC INSURANCE

Client

Legal Name (first, middle, last):	
Date of Birth:	
Home Address:	
City, State, Zip	
Gross Annual Income:	
Estimated Net Annual Income:	
Estimated Household Net Worth:	
Social Security Number:	
State or Country Born In:	
Driver's License Number:	
Driver's License State Issued:	
Driver's License Expiration Date:	
Employer:	
Employer's Address:	
City, State, Zip:	
Employer's Phone Number:	
Occupation:	
List any specializations or degrees acquired in field of occupation:	
Please list exact title at employer:	
Name of Primary Care Physician (PCP):	
PCP Office Address:	
PCP Phone Number:	
Date of Last Visit to PCP:	
Reason for Visit:	
Known Medical Conditions: (yes or none)	
If any known medical conditions, please state below.	
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

The DFS Insurance Group, 5000 Riverside Drive, Building 6, Ste 100E, Irving, TX 75039 | (972) 417-2900

Co-Client

Legal Name: (first, middle, last)	
Date of Birth:	
Gross Annual Income:	
Estimated Net Annual Income:	
Estimated Household Net Worth:	
Social Security Number:	
State or Country Born In:	
Driver's License Number:	
Driver's License State Issued:	
Driver's License Expiration Date:	
Occupation:	
Name of Primary Care Physician (PCP):	
PCP Office Address:	
PCP Phone Number:	
Date of Last Visit to PCP:	
Reason for Visit:	
Known Medical Conditions: (yes or none)	
If any known medical conditions, please state below.	
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

NOTE: Additional medical conditions for the client and/or co-client can be listed on pages 4 thru 6.

INSURANCE UNDERWRITING QUESTIONNAIRE

Please note: *Workplace term insurance is not needed below.*

Client

EXISTING LIFE INSURANCE POLICIES	Policy 1:	Policy 2:
Name of Insurer (Insurance Company):		
Name of Insured (Person covered by policy):		
Type of Policy (Term, Whole Life, IUL, or UL):		
Name of Policy:		
Date of Issue:		
Policy Number:		
Death Benefit Amount:		
Name of Primary Beneficiary:		
Name of Contingent Beneficiary (if any):		

Co-Client

EXISTING LIFE INSURANCE POLICIES	Policy 1:	Policy 2:
Name of Insurer (Insurance Company):		
Name of Insured (Person covered by policy):		
Type of Policy (Term, Whole Life, IUL, or UL):		
Name of Policy:		
Date of Issue:		
Policy Number:		
Death Benefit Amount:		
Name of Primary Beneficiary:		
Name of Contingent Beneficiary (if any):		

Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
• Medication:	
• Dosage:	
• Frequency of Medication:	
• Last Medical Incident:	
• Date of Diagnosis:	

Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
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• Dosage:	
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
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Additional Medical Conditions	Circle One: CLIENT / CO-CLIENT
• Type:	
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• Dosage:	
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• Date of Diagnosis:	