Tonya LeGrande & Associates, LLC

LIFE INSURANCE

PRE-SCREEN HEALTH AND COVERAGE QUESTIONS

Date of Pre-Screen: _____

Agent Name: _____

Client Name:_____ Age: _____ Date of Birth: _____

Address: _____

Phone Number: _____ E-Mail: _____

DEATH BENEFIT AMOUNT

Check the options you are interested in. We can check rates for multiple death benefits.

Proposed Death Benefit: ***Final Expense:*** ☐$10,000 ☐$15,000 ☐$20,000 ☐$25,000 ☐$30,000 ☐$35,000 ☐$40,000

☐ **Universal Life** ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐$90,000 ☐ $100,000 ☐ $120,000 ☐ $150,000

☐$175,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐$350,000 ☐$400,000 ☐$500,000 ☐ $750,000

☐ **Whole LIFE** ☐$1Million ☐$1.5Million ☐$2Million ☐Other: _____

GENERAL UNDERWRITING QUESTIONS

Life insurance is about protecting the people and things that are important to you. When considering life insurance, you must think about your health when qualifying for coverage. It is your health, not your pocketbook, that determines if life insurance makes sense. We break down the key questions to see what options are available to you.

Your Build: Height: _____ Weight: _____ **Tobacco Use:** ☐YES ☐NO IF Yes: Type:_____

How Often: _____

Have you previously been declined Life Insurance? ☐ YES ☐NO

Reason for decline: _____

Are you receiving Worker's Compensation/Disability? ☐YES ☐NO

Reason for Disability: _____

Actively Working? ☐YES ☐NO If NO, please explain: _____

_____

Do you have any family history (parent, sibling) of death before age 70 due to cardiovascular, cerebral vascular disease, diabetes, or cancer? ☐YES ☐NO

If YES, please explain: _____

_____

Within the past 5 years have you had a moving violation, reckless driving, or DUI/DWI? ☐YES ☐NO

If YES, please explain: _____

_____

Any prior convictions? If so, please explain: _____

_____

Do you participate in any dangerous activities (scuba diving, racing, skydiving, etc)? ☐ YES ☐NO

If YES, please explain: _____

_____

Do you intend to travel to any foreign country (excluding Canada)? ☐YES ☐NO

If YES, please explain: _____

_____

U.S. Citizen? ☐YES ☐NO Green Card? ☐YES ☐NO Applying for Citizenship? ☐YES ☐NO

List all prescription medications taken over the past 12 months:

Medication Name:	Amount:	Currently Taking?	How long Taking?	Reason Prescribed:

Have you ever been diagnosed by a licensed physician as having any of the following conditions? (Check all that apply)

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ **Cancer (type)**
- ☐ **COPD (emphysema)**
- ☐ **Strokes/CVA/TIA**
- ☐ Coronary Artery Disease
- ☐ Multiple Sclerosis
- ☐ **Crohn's Disease**
- ☐ Depression/Anxiety
- ☐ **Diabetes (Type)** _____
- ☐ Parkinson's Disease
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Epilepsy (type & date of last) _____
- ☐ Cirrhosis
- ☐ **Asthma**
- ☐ Hepatitis (type) _____
- ☐ Irregular Heart Rate/Palpitations
- ☐ Kidney Disease/Failure
- ☐ **Lupus (type)** _____
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ **Sleep Apnea**
- ☐ High Blood Pressure (readings) _____
- ☐ High Cholesterol (controlled?) _____
- ☐ **Heart Attack**
- ☐ Aneurysm (location, size, operated?)_____ _____
- ☐ Organ Transplant (type) _____
- ☐ **Cardiovascular Disease**

If you answered "YES" to any of the previous questions, provide details here:

Diagnosis: _____ Date: _____
Treatments: _____
Prognosis: _____
Medications: _____

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TYPICAL HEALTH CONCERNS AND MEDICATIONS FOR LIFE INSURANCE PROSPECTS

Asthma

1. Frequency of attacks or hospitalizations? _____
2. Any oral steroids including inhalers that are steroidal? _____
3. Smoker? _____
4. Stable pulmonary function tests? _____
5. Any diagnosis of COPD or emphysema? _____
6. How long diagnosed? _____

Cancer

1. Where cancer originated? _____
2. What stage of cancer, 1-4? _____
4 being metastasis and uninsurable. _____
3. What kind of treatment and last date of treatment, if fully recovered (including surgery, radiation or chemotherapy?
_____
_____
4. When diagnosed? _____
5. PSA for prostate cancer <1? _____
6. If melanoma need Clark Level and depth of invasion? _____

COPD/Emphysema

1. What medications, inhalers, and nebulizer? _____
2. Does the client smoke? _____
3. Need to know if the client has stable pulmonary function tests? _____
4. Any hospitalizations? _____
5. Any limitations or shortness of breath? _____
6. Any oxygen use, daily steroid use or hospitalizations? _____
7. When diagnosed? _____

Crohn's disease

1. When diagnosed? _____
2. What treatment or meds is the client using? _____
3. How frequent are flare-ups or hospitalizations? _____
4. Weight stable? _____

Diabetes

1. What type, 1 or 2? _____
2. When diagnosed? _____
3. How well controlled, last hemoglobin A1C? _____
4. Any diabetic complications (neuropathy (nerve damage), retinopathy (eye), nephropathy (kidney damage), or circulatory problems? _____

_____

5. Weight and height stable and w/in the guidelines? _____
6. What medications, oral or insulin? _____
7. Any heart conditions? _____

Heart disease

1. Any heart surgeries, when and what type, bypass (# of bypasses), angioplasty, pacemaker, or heart valve replacement? _____

_____

2. Recovered? _____
3. What medications taking? _____
4. Any congestive heart failure/atrial fibrillation/heart attack/chest pains. _____
5. Is the client having regular follow-ups and/or testing (last seen and test results) _____

_____

Lupus

1. What type? Discoid or systemic? _____
2. When diagnosed? _____
3. If systemic, what organs affected and how severe are they affected? _____

_____

4. What treatment or meds is the client using? _____
5. How many flare-ups or hospitalizations? _____

Stroke/CVA/TIA – *TIA: Transient Ischemic Attack CVA: Cerebrovascular Accident*

1. How many strokes? _____
2. When was the episode? _____
3. Any residuals, such as numbness, weakness, pain, slurred speech, or visual impairment? _____

_____

4. Any limitations that require cane or assistance? _____
5. Any findings on a CT of white matter changes, small vessel disease, ischemic changes, micro vascular changes and lacunar infarcts? _____
6. Any cognitive abnormalities? _____

Sleep Apnea

1. When diagnosed? _____
2. Severity of the condition? _____
3. Does the client use a CPAP machine? Is the machine hooked to oxygen? If it is then companies will decline. _____

_____

4. Any other treatment? _____
5. Stable pulmonary function tests? _____

Additional Information:

Thank you for taking the time to complete this information. Our office works with several carriers and will do our best to find you affordable coverage.

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