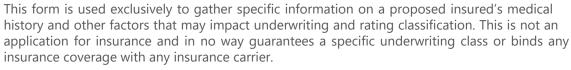
Underwriting Questionnaire

Pre-Underwriting





PRODUCER INFORMATION (this section must be completed)						
Name		Producer Number				
Phone Email Address	5					
Have you submitted this case previously? Yes No						
CLIENT HISTORY (this section must be completed)						
Client Name			State			
Male Female Date of Birth		Age	Height	Weight		
Average weight change in the past 12 months	Average weight change in the past 12 months		Occupation			
Is the client a Foreign National? Yes No If yes,	, list country	of citizenship				
Has the client traveled outside the United States? Yes No	If yes, list the countries and dates visited					
Green Card? Yes No						
Type of Visa						
REQUESTED COVERAGE (this section must be completed	l)					
Universal Life Survivorship Variable Life Whole Life LTC Rider Term, Level Period						
If you are replacing coverage, will there be any 1035 money with this replacement? Yes No If yes, what amount will be carried over?			nent? Yes No			
Has the case been submitted to other companies in the last 12 months? Yes No If Yes, list companies, dates, and action taken						
TOBACCO/NICOTINE USAGE USAGE (this section must	t be comple	eted)				
Has your client ever smoked cigarettes:		,				
Yes No If yes, date of last usage:						
Has your client used other tobacco or nicotine containing products	(examples:	cigars, pipe, snuff, nicotine	gum or patch) Ye	s No		
If yes, provide types and last date of use:						
MARIJUANA & CBD OIL USAGE (this section must be completed)						
Does your client use marijuana Yes No If yes, complete the following:						
Purpose Recreational/Social Medicinal Frequency times per Day Month Year						
Delivery Method Ingested Vaporized Inhaled Date Last Used						
Does your client use CBD oil? Yes No If yes, complete the following:						
Frequency times per Day Month Year						
Delivery Method Ingested Vaporized Topical Date Last Used						



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Underwriting Questionnaire

Pre-Underwriting



MEDICAL HISTORY (this section	must be completed)						
	D	octor's name, ad	dress, phone	Date	Illness/Reason		
Who is your client's primary care physicia When did your client last consult him/he Any ongoing medical treatment?							
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)							
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client ever been treated?							
List all medications, including over-the-counter drugs and vitamins							
FAMILY HISTORY (this section mu	FAMILY HISTORY (this section must be completed)						
Have any immediate family members (pare	nts, siblings) been diagno	osed or died from	heart disease, cancer	, or diabetes? If yes, p	rovide details below. Yes No		
Relation (mother, father, brother, sister)	Diagnosis	5	Approximate age	e of disease onset	(if deceased) age at death		
DRUG AND ALCOHOL USAGE	check here if this s	section is not app	licable				
Does your client currently drink alcohol?	Yes No		Has your client ever drank substantially more than present? Yes No				
Type(s) of Alcohol			If yes, when?				
			consulted a doctor or re	eceived treatment because of alcohol use?			
How much per week Yes No If yes, provide details							
Has your client ever used illegal drugs or sought treatment because of drug use? Yes No							
If yes, provide details							
Type of drug(s) used					Date of last use		
CORONARY check here if this	s section is not applicab	le					
Date of diagnosis or first chest pain			Number of disease	d vessels			
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)							
Date of last stress EKG	Results				By whom?		
Any pain since treatment/surgery?							



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Underwriting Questionnaire

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CANCER check here if this section is not applicable							
Exact name and location of cancer		Stage and grade					
Who would have the pathology report		Date/details of treatment/surgery					
DIABETES check here if this s	ection is not applicable						
Date of diagnosis	Treatment Diet only Oral med	lication Insulin Details					
Does your client regularly test his/her blood glucose? Yes No	Results	Frequency					
Latest result of glycohemoglobin (A1C)	testmg% Date						
Has your client been diagnosed with ha	ving protein and/or microalbumin in urin	e? Yes No					
Have your client ever had: Eye trouble Yes No Heart trouble Yes No High blood pressure Yes No Have your client ever had: Kidney trouble Yes No Neuritis/Neuralgia Yes No Insulin reactions Yes No							
MENTAL DISORDERS/DEPRES	SSION/ANXIETY check here if	this section is not applicable					
Date of diagnosis	Hospitalization Yes No	Suicide attemp(s) Yes No	Currently employed Yes No				
Medications							
SLEEP APNEA check here if t	his section is not applicable						
Date of diagnosis	his section is not applicable						
Date of diagnosis	Is a CPAP used every night Yes	No Date of last sleep s	,				
Sleep study results Mild Moderate Severe Was surgery done Yes No If yes, type of surgery							
HAZARDOUS ACTIVITIES	check here if this section is not applicab	ole					
Is your client a private pilot? How many total hours has your client Yes No If yes, provide details. How many total hours has your client flown as Pilot in Command?		How many hours does your client fly per year?	Does your client have an IFR (instrument flight rating) Yes No				
Does your client participate in the following activities? (check those that apply) □ Scuba Diving □ Bungee Jumping □ Ultralight Flying □ Sky Diving							
☐ Mountain Climbing		uto/Motorcycle Racing					
DRIVING HISTORY check	there if this section is not applicable						
DUI/DWI Reckless Driving		Suspensions	Any moving violations in the last five years?				
Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Multiple Sclerosis, TIA/CVA,							
etc.)? If so, please describe below and include additional pages if more space is needed. Impairment Not Listed Date of Diagnosis Treatment Medication(s) Date of Last Follow-Up Test Results							
	Date of Diagnosis	Treatment Medication(s)	Date of East Follow-op Test Results				



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