Informal Medical Questionnaire

Personal History—Proposed Insured

Name _____ ☐ Male ☐ Female Social Security Number _____

US Citizen? ☐ Yes ☐ No Date of Birth _____ Birth State _____ Phone _____

Age _____ Height _____ Weight _____ Driver's License Number _____ Driver's License State _____

Address _____ City _____ State _____ Zip _____

Lifestyle

Did you lose/gain more than 10 pounds in the past year? ☐ Yes ☐ No If yes, explain reason for weight change: _____

_____

Have you ever used or do you currently use any form of tobacco or nicotine delivery system? ☐ Yes ☐ No

☐ Cigarettes ☐ Chewing tobacco ☐ Cigars ☐ Pipe ☐ E-Cigarettes ☐ Vape ☐ Zyn Other: _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly Date Last Used _____

Do you currently use marijuana products? ☐ Yes ☐ No

☐ Medicinal ☐ Recreational Options: ☐ Smoking ☐ Vaping ☐ Edibles ☐ Topical ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly Date Last Used _____

Any history of treatment of drug/alcohol use? ☐ Yes ☐ No If yes, explain or complete alcohol/drug questionnaire: _____

_____

Any history of moving violations? ☐ Yes ☐ No If yes, explain or complete driving questionnaire: _____

_____

Are you a pilot and/or do you participate in any activities such as scuba diving, rock climbing, motor cross, etc.? ☐ Yes ☐ No

If yes, provide details: _____

Do you intend to reside or travel outside of the United States within the next two years? ☐ Yes ☐ No

If yes, please provide city, country, dates/duration and purpose of all travel: _____

_____

Requested Coverage

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship ☐ Variable Is LTC desired? ☐ Yes ☐ No

Face amount desired $ _____ Premium amount desired $ _____

What will be the purpose of the insurance? _____

Have you ever been declined or rated when applying for life insurance? ☐ Yes ☐ No

If yes, when and why? _____

THE PINNACLE GROUP

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Existing Insurance *Do you currently have active insurance coverage? Will this coverage be replaced?*

Company	Type	Amount	Replacing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medical History *Please answer the following questions and provide detail to any "yes" answers.*

Who is your personal physician? (Doctor's name, address, and phone number)

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

What other medical practitioners or health care providers have you consulted in the past 5 years, not including insurance examinations?

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

In what clinics or hospitals have you been treated?

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

Please list all current medications, purposes, and doses (both prescribed and non-prescribed)

Do you have any upcoming procedure or office visit planned with any physician? ☐ Yes ☐ No

If yes, please give details: _____

Informal Medical Questionnaire

Medical History Continued *Please answer the following questions and provide detail to any "yes" answers.*

Any cancer, cardiovascular, or diabetes history/deaths prior to age 60 among your parents or siblings? ☐ Yes ☐ No

	If living, please provide age:	If deceased, please provide age at death and cause of death:		Cancer of any type
Mother	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Father	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Sibling	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Sibling	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:

Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heartbeat, or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No

Diabetes or disease of any glands? ☐ Yes ☐ No

Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? ☐ Yes ☐ No

Arthritis, gout, or any bone, joint, muscle, or skin disorder? ☐ Yes ☐ No

Asthma, bronchitis, pneumonia, emphysema, or any lung disorder? ☐ Yes ☐ No

Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder pancreas, stomach, or intestines? ☐ Yes ☐ No

Prostate of testicular disease, disease of the uterus, ovaries, or breast? ☐ Yes ☐ No

Anemia, leukemia, clotting disorders, or platelet disorders? ☐ Yes ☐ No

Disorder of the urinary tract or kidneys - sugar, albumin, or blood in the urine? ☐ Yes ☐ No

Cancer or tumors? ☐ Yes ☐ No

An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance)? ☐ Yes ☐ No

Any other health impairment or medically treated condition not previously mentioned? ☐ Yes ☐ No

Within the last 10 years, have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS in the space below. Attach additional pages if necessary. Please be specific with this information for it will expedite the process.

Agent Information

Name _____ Firm _____

Social Security Number _____ Phone _____