ISG Insurance Solutions Group
LifeMark PARTNERS The strength of many. The power of one.

Insurance Solutions Group
405 Legacy Park, Ridgeland, MS 39157
T: 601.362.9546 F: 601.362.8587 TF: 800.873.5754
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COMPLETE EVALUATOR

– Give concise, detailed answers to all questions.
– Provide accurate dates of all treatments.

Writing Agent Name _____

Home / E-mail _____

– Give full names and addresses of all physicians and hospitals.
– Complete Diabetes, Heart, Cancer or Alcohol Questionnaires if applicable.

"**<u>This is not an application for insurance.</u>** The form is used exclusively to gather specific information on your medical history and other factors that may impact underwriting and rating classifications. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier."

PROSPECT

Sex M ❑ F ❑

Name *(Please Print)* _____
(Last) (First) (MI)

Date of Birth _____ Place of Birth _____

Social Security # _____

Married ❑ Single ❑ Divorced ❑ Widowed ❑

Residence Address _____
Street City State Zip

Occupation *(Type of industry, duties)* _____

Plan: Term ❑ # Yrs._____ Whole Life ❑ Universal ❑

Face Amount $_____

Amount of Insurance in Force $_____

Is this insurance intended to replace or change existing insurance or annuity? Yes ❑ No ❑

If "Yes", provide name of company, plan, amount and issue date in #8.

Last rated offer for insurance was $_____ per thousand,

on _____/_____/_____, Table _____

By the _____ Life Insurance Co.
(Name of Company)

MEDICAL HISTORY

1. Height _____feet _____inches Weight _____ lbs.
2. Do you smoke cigarettes?
   a. If "Yes", for how long? _____ years
   b. If "No", ❑ Never smoked
      ❑ Stopped smoking _____ yrs ago

   Cigarettes formerly smoked per day _____

   Do you use nicotine in any other form? Yes ❑ No ❑
   a. If "Yes", ❑ Pipe ❑ Cigar ❑ Chew ❑ Snuff ❑ Gum/Patch/Other
   b. Amount used per day _____
3. Are you currently taking medication or under treatment for any disease, condition, or disorder? Yes ❑ No ❑

HAVE YOU EVER HAD:

4. a. Insurance or reinstatement declined, postponed, limited, or offered on a special class or basis? Yes ❑ No ❑
   b. Any past, present, or expected aviation activities or hazardous sports, avocation, hobbies? Give frequency, type, special hazards. (See #9) Yes ❑ No ❑
   c. Heart problems (murmur, pain, or pressure in chest, shortness of breath, or heart attack)? If "Yes", complete Question #9 and coronar artery disease questionnaire on page 2. Yes ❑ No ❑
   d. Treatment for high blood pressure? Yes ❑ No ❑
   e. Diabetes? If "Yes", complete Question #9 and diabetes questionnaire on page 2. Yes ❑ No ❑
   f. Cancer or tumor? If "Yes", complete Question #9 and cancer questionnaire on page 2. Yes ❑ No ❑
   g. Epilepsy, fainting spells, nervous or mental condition, or any disorder of brain or nervous system? Yes ❑ No ❑
   h. Disorder of lungs or respiratory system? Yes ❑ No ❑
   i. Disorder of stomach, intestines, rectum, liver, kidney, or gall bladder? Yes ❑ No ❑
5. Have you ever had license suspended or revoked? If "Yes", why and when. Yes ❑ No ❑
   _____
6. Have you used narcotics, sedatives, or tranquilizers not prescribed by M.D.? Yes ❑ No ❑
7. List any other condition that is not brought out above? If "Yes", complete Question #9. Yes ❑ No ❑

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
FATHER			
MOTHER			
Sister, Brothers Number Living _____ Number Dead _____			

8. Name and address of your personal physician, along with the date and reason you last consulted them.

9. Please provide details to all "Yes" answers (number, name & address of physician / hospital treating, dates, etc.)

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PROSPECT'S DIABETIC QUESTIONNAIRE

1. Date Diabetes diagnosed _____ Height _____ Weight _____ Weight two years ago _____
2. Name and address of physician presently supervising your diabetes _____
3. Fasting Blood sugar: Date _____ Result _____
4. Glycohemoglobin A1C: Date _____ Result _____
5. What is present treatment: Diet only _____ Oral Medication _____ Insulin _____ Units per day _____
6. Have you ever had: Kidney disorder? _____ Eye disorder? _____ Hypertension? _____ Heart disorder? _____
   Neuropathy? _____
7. Has an Electrocardiogram been taken? _____ Date _____ Stress Test _____ Date _____
   By Whom? _____
   Was the Electrocardiogram reported normal? _____ Was the Stress Test reported normal? _____

PROSPECT'S HEART DISEASE QUESTIONNAIRE

A. Have any of the following ever been experienced:	YES	NO	B. Was it associated with:	YES	NO
1. Chest Pain?	❑	❑	1. Exertion? Exercise?	❑	❑
2. Palpitation?	❑	❑	2. Excitement? Strain?	❑	❑
3. Shortness of Breath?	❑	❑	3. Meals?	❑	❑
4. Heart Attack?	❑	❑			

C. 1. Approximate date of first episode _____ 2. Date of last episode _____
3. How frequently did the episodes occur? _____
4. Duration of episodes _____
5. Hospitalized? _____ Date Admitted _____ Date Discharged _____
6. Was bypass surgery done? _____ Single _____ Double _____ Triple or More _____
7. Was angioplasty done? _____
8. When was the last electrocardiogram taken? _____ Stress / Treadmill test? _____
9. Have you ever had an angiogram or heart catherization? _____ Date _____
10. Date of return to work? _____ Restrictions? _____
11. What medication is taken now? _____
12. What **DIAGNOSIS** was made concerning the heart condition? _____
    _____

D. Give names and addresses of all physicians consulted:

PROSPECT'S ALCOHOL USAGE QUESTIONNAIRE

1. Do you consume alcohol at the present time? YES ❑ NO ❑
2. Are you involved in AA or any other support group? YES ❑ NO ❑
3. Have you ever had alcohol treatment or counseling? YES ❑ NO ❑
4. Date of last drink? _____
5. Any D.U.I.'s? _____ Date _____

PROSPECT'S CANCER QUESTIONNAIRE

1. Date of diagnosis _____ 2. Type of Cancer (give full medical name) _____
3. Stage, level or grade (please contact your physician if not known) _____
4. Location of cancer _____
5. Type of treatment given _____
6. Date treatment started _____ Last treatment _____
7. Date of last follow-up _____ **8. If cancer less than 10 years ago, please obtain pathology report.**
9. Give names and addresses of all physicians consulted:

CLICK HERE WHEN COMPLETE TO SEND TO ISG OR FAX 601.362.8587