

DRUG-USAGE QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
BGA: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. Indicate any of the following drugs you are currently using or have used in the past:
- | | | | | |
|--|---|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Opium derivatives | <input type="checkbox"/> Heroin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> Amytal | <input type="checkbox"/> Seconal | <input type="checkbox"/> Nembutal |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Hashish | <input type="checkbox"/> Cannabis | | |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Benzedrine | <input type="checkbox"/> Dexedrine | <input type="checkbox"/> Methedrine | |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Crack | <input type="checkbox"/> Any derivatives | | |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> LSD <input type="checkbox"/> DMT | <input type="checkbox"/> Mescaline | <input type="checkbox"/> Peyote | <input type="checkbox"/> Psilocybin |
| <input type="checkbox"/> IV drug use: | | | | |
| <input type="checkbox"/> Other: | | | | |

2. Please note details on the above mentioned:

Type:	Quantity:
Frequency:	Date last used:
Type:	Quantity:
Frequency:	Date last used:
Type:	Quantity:
Frequency:	Date last used:
Type:	Quantity:
Frequency:	Date last used:

3. Do you consume any alcohol? No Yes, Details:

4. Have you ever suffered from any liver disorder (i.e., enlarged liver, elevated Liver Function Tests) due to drug use? No Yes, Details:

5. Have you ever been confined to bed, or lost your job due to your connection with drugs?
 No Yes, Details:

6. Have you ever been arrested or charged in connection with the drugs?
 No Yes, Details:

7. Have you had any moving traffic violations in the last 5 years? No Yes, Details:
- | | | | |
|---|---------|--------------------|--|
| <input type="checkbox"/> Violations | Number: | Type: | Dates: |
| <input type="checkbox"/> Accidents | Number: | Were you at fault? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> License suspensions or revocations : | Dates: | | |
| Reasons | | | |

8. Are you on any medication(s)? No Yes, Name(s) and dosage(s):

9. Date you last consulted your physician:

10. Have you ever received treatment or counseling, consulted or been advised by a doctor, medical facility, or support group (Alcoholics Anonymous, Narcotics Anonymous, etc.) because of your drug use?

No Yes, Name and address(es) of any doctor(s), hospital(s), and/or treatment center(s):

11. Has case been shopped elsewhere, if so where & when?
Date: _____