

GASTRO/INTESTINAL 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. Date you first experienced symptoms?
2. What is your actual diagnosis?
3. Date of your last attack?
4. How often do you have attacks?
5. Are the attacks becoming more frequent? Yes No
6. Do you experience any of the following?
 Black stools Vomiting Bleeding Relieved by eating
7. Have you had any weight loss in the past 6 months? No Yes, Amount:
8. Have you had any surgery(ies) for this disease?
 No Yes, Date(s):
Details:
9. How often do you have a full work-up for your gastro/intestinal problem?
10. What tests or procedures does the complete work-up include?
11. Are you on any medication(s)? No Yes, Details:
12. Date you last consulted your physician:
13. Name and address of your physician(s):

Underwriter's Notes:

Date: _____
