

LIVER 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. What is your actual diagnosis?
2. When were you diagnosed?
3. What were your first symptoms?
4. Please indicate dates and tests that have been completed to give you this diagnosis?
Date: _____ Test: _____
Results: _____
Date: _____ Test: _____
Results: _____
Date: _____ Test: _____
Results: _____
Date: _____ Test: _____
Results: _____
5. Indicate your current liver function levels, if known?
6. Have you ever been diagnosed with any of the following, if yes provide details and complete the additional relative questionnaire(s):
 Hepatitis Crohns Ulcerative colitis Alcoholism Drug Abuse
Details: _____
7. Have you ever had a gall bladder problem? No Yes, Details: _____
8. Have you ever had any surgeries? No Yes, Details: _____
Date(s): _____
9. Are you on any medication(s)? No Yes, Name(s) and dosage(s): _____
10. Date you last consulted your physician: _____
11. Name and address of your physician(s): _____

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____