



Prescreening Guide for Life Coverage

Full Name (& former names): _____ Date of Birth: ____/____/____

Social Security #: _____ Ph#: _____ Email: _____

Height/ Weight	Height: Ft. ____ In. ____ Weight: _____ lbs. BMI less than 29: <input type="checkbox"/> No <input type="checkbox"/> Yes http://www.bmi-calculator.net/	Severe Medical Conditions Diagnosed <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> Check all that apply & explain </div>	<input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiovascular/ Heart Disease <input type="checkbox"/> Cor. Artery Disease <input type="checkbox"/> Crohn's Disease (Ileitis) <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Diabetes* <input type="checkbox"/> Epilepsy/Convulsions <input type="checkbox"/> Gastric/Peptic Ulcers <input type="checkbox"/> Heart Attack <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney or Liver Disease (chronic) <input type="checkbox"/> Lupus <input type="checkbox"/> Melanoma <input type="checkbox"/> Mental/Emotional Cond. <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Vascular Disease
Nicotine Usage	<input type="checkbox"/> Never <input type="checkbox"/> Currently since _____ <input type="checkbox"/> Quit on _____ after a period of _____ years Type*: <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> chew <input type="checkbox"/> e-cigs <input type="checkbox"/> pipe Marijuana use: <input type="checkbox"/> No <input type="checkbox"/> Yes* * Frequency: _____		*Diabetes
Blood Pressure	Systolic blood pressure: _____ Diastolic blood pressure: _____ Taking BP medication: <input type="checkbox"/> No <input type="checkbox"/> Yes	Higher Risk Activities	<input type="checkbox"/> Ballooning <input type="checkbox"/> Bungee Jumping <input type="checkbox"/> Hang Gliding / Parachuting / Sky Diving <input type="checkbox"/> Motor Sports of any type <input type="checkbox"/> Pilot / Student Pilot / Flight Crew <input type="checkbox"/> Rock / Mountain Climbing <input type="checkbox"/> Scuba / Skin Diving <input type="checkbox"/> Spelunking <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> Check all that apply & explain </div>
Cholesterol	Cholesterol level: _____ HDL ratio: _____ Taking Cholesterol medication: <input type="checkbox"/> No <input type="checkbox"/> Yes Cholesterol/HDL above 4.5: <input type="checkbox"/> No <input type="checkbox"/> Yes https://www.omnicalculator.com/health/cholesterol-ratio	Driving Record (last 5 years)	Ever convicted of a moving violation, received a DUI, or had license suspended or revoked? <input type="checkbox"/> No <input type="checkbox"/> Yes* If "yes," list details that will surface in the MVR.
Medical Treatment	Prescribed/OTC Meds in the last 5 years: <input type="checkbox"/> No <input type="checkbox"/> Yes* Hospitalization in the last 10 years: <input type="checkbox"/> No <input type="checkbox"/> Yes** Physician/psychologist visits in the last 5 years: <input type="checkbox"/> No <input type="checkbox"/> Yes** *Dosage, freq, physician, duration, reason **Name, location, date, reason, outcome	Misc.	<input type="checkbox"/> Ever convicted or awaiting trial for a felony: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Plan on traveling outside the U.S. for business or pleasure in the next 12 months: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Permanent citizen/resident of U.S. or Canada: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Member of the Armed Forces or planning to apply: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Annual Earned Income: \$ _____ <input type="checkbox"/> Net Worth: \$ _____ <input type="checkbox"/> Bankruptcy in the last 5 years: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Is this a replacement life policy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Had a life app modified, rated, declined, postponed: <input type="checkbox"/> No <input type="checkbox"/> Yes
Family History	Prior to age 70, parents & sibling(s): <i>Deceased?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>Cancer?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>Cardiovascular Disease?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes* *Provide relationship, age of onset, age/cause of death.	Alcohol Usage <input type="checkbox"/> Never <input type="checkbox"/> Current (Type/# per wk: _____) <input type="checkbox"/> Quit (last used: _____) History of/treated for alcohol or substance abuse: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain any "Yes" answers or "Checked" conditions. For medical conditions, include onset dates/duration, symptoms, complications, severity, treatment, medication, treating provider/location, outcome, etc. <i>The more, the better!</i> GP Agency 7000 Six Forks Rd., Suite 103, Raleigh, NC 27615 (919) 834-7937 www.gpagecy.com <div style="text-align: right;">(1/15/2021)</div>	
Alcohol Usage			