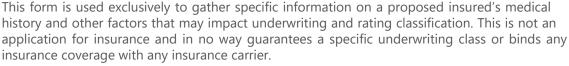
Underwriting Questionnaire

Pre-Underwriting





PRODUCER INFORMATION (this section must be completed)						
Name			Crump Producer Number			
Phone	Email Address	Address				
Have you submitted this case previously? Yes	No					
CLIENT HISTORY (this section must be comp	oleted)					
Client Name				State		
Male Female	Date of Birth	,	Age	Height	Weight	
Average weight change in the past 12 months			Occupation			
Is the client a Foreign National? Yes No	Is the client a Foreign National? Yes No If yes, list country of citizen			hip		
Has the client traveled outside the United States? Yes No	If yes, list the cou		ntries and dates visited			
Green Card? Yes No						
Type of Visa						
REQUESTED COVERAGE (this section must	be completed)					
Universal Life Survivorship Variable Life Whole Life LTC Rider Term, Level Period						
Face amount desired?	If you are replacing If yes, what amount	are replacing coverage, will there be any 1035 money with this replacement? Yes No what amount will be carried over?				
Has the case been submitted to other companies in the last 12 months? Yes No If Yes, list companies, dates, and action taken						
TOBACCO/NICOTINE USAGE USAGE (thi	is section must be c	omplet	ted)			
Has your client ever smoked cigarettes:						
Yes No If yes, date of last	t usage:					
Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch)						
If yes, provide types and last date of use:						
MARIJUANA & CBD OIL USAGE (this section must be completed)						
Does your client use marijuana Yes No If yes, complete the following:						
Purpose Recreational/Social Medicinal Frequency times per Day Month Year						
Delivery Method Ingested Vaporized Inhaled Date Last Used						
Does your client use CBD oil? Yes No If yes, complete the following:						
Frequency times per Day Month Year						
Delivery Method Ingested Vaporized Topical Date Last Used						



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Underwriting Questionnaire

Pre-Underwriting



MEDICAL HISTORY (this section must be completed)								
		Doctor's name, ad	dress, phone	Date	Illness/Reason			
Who is your client's primary care physician When did your client last consult him/her? Any ongoing medical treatment?								
What other physicians has your client cons (do not include insurance examinations)	sulted during							
In what hospitals, clinics, drug/alcohol trea ever been treated?	atment center							
List all medications, including over-the-counter drugs and vitamins								
FAMILY HISTORY (this section must be completed)								
Have any immediate family members (parent			heart disease, cancer	, or diabetes? If yes, p	rovide details below. Yes No			
Relation (mother, father, brother, sister)		Diagnosis	Approximate age of disease onset		(if deceased) age at death			
DRUG AND ALCOHOL USAGE	check her	e if this section is not app	olicable					
Does your client currently drink alcohol?	es your client currently drink alcohol? Yes No		Has your client ever drank substantially more than present? Yes No					
Type(s) of Alcohol			If yes, when?					
Date of last consumption			Has your client ever consulted a doctor or received treatment because of alcohol use?					
How much per weekYes [Yes No If	Yes No If yes, provide details				
Has your client ever used illegal drugs or s	sought treatm	ent because of drug use?	Yes No					
If yes, provide details								
ype of drug(s) used Date of last use								
CORONARY check here if this s	section is not	applicable						
Date of diagnosis or first chest pain Number of diseased vessels								
Dates/details of treatment/surgery (examp	oles: Angiopla	sty, Bypass)						
Date of last stress EKG R	Results				By whom?			
Any pain since treatment/surgery?					-			



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Underwriting Questionnaire

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CANCER check here if this section is not applicable							
Exact name and location of cancer		Stage and grade					
Who would have the pathology report		Date/details of treatment/surgery					
DIABETES check here if this section is not applicable							
Date of diagnosis	Treatment Diet only Oral med	lication Insulin Details					
Does your client regularly test his/her blood glucose? Yes No	Results		Frequency				
Latest result of glycohemoglobin (A1C)	testmg% Date	·					
Has your client been diagnosed with ha	ving protein and/or microalbumin in urin	e? Yes No					
Have your client ever had: Eye trouble Yes No Heart trouble Yes No High blood pressure Yes No Have your client ever had: Kidney trouble Yes No Neuritis/Neuralgia Yes No Insulin reactions Yes No							
MENTAL DISORDERS/DEPRES	SSION/ANXIETY check here if	this section is not applicable					
Date of diagnosis	Hospitalization Yes No	Suicide attemp(s) Yes No	Currently employed Yes No				
Medications							
SLEEP APNEA check here if t	his section is not applicable						
Date of diagnosis	Is a CPAP used every night Yes	No Date of last sleep s	tudy				
Sleep study results Mild Moderate Severe Was surgery done Yes No If yes, type of surgery							
HAZARDOUS ACTIVITIES	check here if this section is not applicat	ple					
Is your client a private pilot? How many total hours has your client Yes No If yes, provide details. flown as Pilot in Command?		How many hours does your client fly per year?	Does your client have an IFR (instrument flight rating) Yes No				
□Scuba Diving							
☐ Mountain Climbing		uto/Motorcycle Racing	er				
	here if this section is not applicable						
DUI/DWI Reckless Driving		Suspensions	Any moving violations in the last five years?				
Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Multiple Sclerosis, TIA/CVA, etc.)? If so, please describe below and include additional pages if more space is needed.							
Impairment Not Listed	Date of Diagnosis	Treatment Medication(s)	Date of Last Follow-Up Test Results				



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