BROOKFIELD PARTNERS

Gastric Bypass Questionnaire

UNDERWRITING QUESTIONNAIRE

AGENT & CASE INFORMATION

AGENT NAME | PHONE | E-MAIL

PROPOSED INSURED

CLIENT NAME | DATE OF BIRTH | STATE

HEIGHT | WEIGHT | FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. When did the proposed insured have gastric bypass surgery?

2. What was the proposed insured's weight prior to having surgery?

3. How long as the proposed insured maintained their current weight?

4. Did the proposed insured received treatment for medical conditions prior to the surgery that no longer require treatment? (e.g., diabetes, hypertension, heart disease) ☐ Yes ☐ No

Please provide details including condition, treatment received and when treatment ended:

5. Is the proposed insured currently taking any medication? ☐ Yes ☐ No

If yes, please provide the name, dosage and condition they are taking the medication for:

Please e-mail the completed form to Brad Kadelski · brad@brookfieldpartners.com

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