

Pre-Application Checklist - Clients



Before submitting a disability insurance (DI) application, please discuss your financial and medical history with your financial professional. Answering "yes" to any of the following questions could cause the underwriting results to be different than quoted, or possibly declined with the intended carrier. **It is important to discuss details with your financial professional to increase the likelihood of an expected offer.**

Your Name _____

KNOCKOUT QUESTIONS - DO NOT SEND QUOTE REQUEST/CASE IS A DECLINE

If you answer "yes" to any of the questions within this section, contact your agent - DO NOT send the application.

Are you pending any surgery? Yes No

Are you in the military with active deployment papers? Yes No

Have you filed for bankruptcy or had a bankruptcy discharged in the last two years? Yes No

POSSIBLE EXCLUSION/IMPAIRED RISK QUESTIONS

If you answer "yes" to any of the questions within this section, contact your agent to discuss possible solutions.

TOBACCO/NICOTINE/MARIJUANA USAGE

Do you smoke cigarettes or use other nicotine and/or marijuana products? Yes No

If yes, which product(s) do you use? Cigarettes Tobacco/Nicotine Products
 Marijuana — Recreational Medicinal How frequently? _____

HEIGHT/WEIGHT/BUILD-RELATED CONCERNS

What is your? Height _____ Weight _____

Have you undergone a gastric bypass procedure in the last five years? Yes No

MEDICAL PROCEDURES/SURGERIES

Do you have any planned or pending tests that need to be completed by a physician? Yes No

Are you regularly seeing a chiropractor or have you been seen by one in the last two to three years? Yes No

Have you ever had joint replacement? Yes No

Have you had fracture repair using metal plates, pins or other hardware? Yes No

MEDICAL DIAGNOSIS

Have you been diagnosed with any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pregnancy Complications
(under age 50) |
| <input type="checkbox"/> Crohn's Disease or Colitis | <input type="checkbox"/> Cardiovascular Disorder (Heart
Attack, Stroke, Other) | <input type="checkbox"/> Sleep Apnea
If yes, is CPAP used? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cancer (in last 10 years)
If yes, Type? _____
If yes, date of diagnosis? _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Type 1 or Type 2 Diabetes
If yes, Type 1 or Type 2? _____
If yes, date of diagnosis? _____
If Type 2, last A1C reading? _____ |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | |
| | <input type="checkbox"/> Lupus | |
| | <input type="checkbox"/> Multiple Sclerosis | |

MENTAL/PSYCHOLOGICAL

Are you taking medication for a mental or psychological condition? Yes No

If yes, what is the specific condition? _____

If yes, what is the medication? _____ What milligram? _____

Are you currently taking anxiety medication(s) prescribed due to work-related stress? Yes No

Are you currently taking medication prescribed for ADHD? Yes No

Contact your broker for more information.

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