



INSURED MEDICAL QUESTIONNAIRE
(Print or type clearly)

PERSONAL INFORMATION

1. Name of Insured: _____ Date of Birth: _____
2. Height: _____ Weight: _____ Sex: Male Female

LIFESTYLE AND HABITS

3. Has your weight changed in the last year? Yes No If yes, provide details: _____

4. Do you currently, or have you ever smoked cigarettes? Yes No If yes, for how many years? _____
If yes, how many daily? _____ Date of last use (if currently, write "current"): _____
5. Do you use any other form of tobacco? Yes No If yes, indicate type and frequency: _____
6. Do you drink beer, wine or spirits? Yes No If yes, indicate type and number of drinks per day: _____
7. Do you currently engage in sports or regular exercise? Yes No
If yes, provide details of type and frequency: _____

8. Do you live alone? Yes No If no, with whom? Spouse Significant other Other
9. Do you live in an assisted living facility or nursing home? Yes No
10. Are you in the process of entering assisted living facility or a nursing home? Yes No
11. Do you require assistance to perform any of the following activities? Yes No
If yes, check all that apply:
 Driving Walking Bathing Dressing Taking Medication Eating/Meal Planning
 Transferring (*Lifting and moving oneself from one place to another such as from a bed to a chair.*)
If yes, provide details: _____

MEDICAL HISTORY, CONDITIONS AND TREATMENTS

12. In the past five years, have you been diagnosed with or treated for any of the following conditions? (*Check all conditions that apply and provide details below*)
- Disease or disorder of the heart including atrial fibrillation, heart attack, coronary artery disease, etc.?
 - Circulatory disorder including stroke, TIA (*mini-stroke*), aneurysm, arterial blockage, etc?
 - Cancer, tumor or malignancy?
 - Any immune system disorder?

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- Disease or disorder of the digestive system including diabetes, liver disease, colon, or any other?
- Disease or disorder of the lungs or respiratory system including asthma, emphysema, COPD, or any other?
- Neurological disorders including Parkinson's disease, multiple sclerosis, convulsions, epilepsy, or any other?
- Mental or nervous disorder including dementia, memory or cognitive impairment, psychiatric disorder or any other?

Please provide details for any of the disorders that were checked above (*attach additional pages as necessary*):

13. Have you been diagnosed with, been treated for, had surgery or are currently being treated for any other disease or disorder not previously listed? Yes No

If yes, provide details (*attach additional pages as necessary*): _____

FAMILY HISTORY AND PRESCRIPTION MEDICATIONS

14. Mother's age, if living _____ if deceased, age at death _____ cause of death _____

15. Father's age, if living _____ if deceased, age at death _____ cause of death _____

16. Sibling's age, if living _____ if deceased, age at death _____ cause of death _____

Sibling's age, if living _____ if deceased, age at death _____ cause of death _____

17. Please list all prescription medications currently being used (*attach additional pages as necessary*):

The undersigned insured and agent hereby represent and warrant that any and all information provided in this questionnaire is true and correct as of the date hereof. Each undersigned hereby affirms its understanding that Life Insurance Settlements, Inc. and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("LIS") will be relying on the statements and responses which are being provided by the undersigned in this questionnaire, and each undersigned agrees, jointly and severally, to hold LIS harmless and agrees to indemnify LIS from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

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NAME OF INSURED

SIGNATURE OF INSURED

DATE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE