OAKTREE Brokerage
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(p) 800-842-9124
(f) 888-756-5954

CLASSIFICATION QUESTIONNAIRE

Agent's Name _____ Agent's Phone _____ Fax/E-mail _____

Client Name	D.O.B.	Citizenship
Height _____ ft. ____ in.	Weight _____ lbs.	Sex ( ) Male ( ) Female
Plan of Insurance (circle) / Amount Desired Term UL $	Anticipated Premium or Class (circle) $ Super-Preferred / Preferred / Super Standard / Standard	

- Lost weight in last year? ( ) Yes ( ) No How much: _____ lbs.
- Tobacco use in any form? ( ) Yes ( ) No If yes, give form and frequency: _____
- Recently stopped using tobacco? ( ) Yes ( ) No If yes, when: _____
- Adverse motor vehicle report? ( ) Yes ( ) No If yes, please detail: _____
- Any family history of disease? ( ) Yes ( ) No If yes, list family member, age if living or age at death and cause (heart disease, vascular disease, cancer)
  Adopted? ( ) Yes

  _____

  _____
- High blood pressure or elevated cholesterol? ( ) Yes ( ) No If yes, current reading: BP _____ / Chol _____
  Highest reading: BP _____ / Chol _____ HDL reading or ratio: _____
- Ever been hospitalized? ( ) Yes ( ) No If yes, please detail: _____

  _____
- Any history of the following? (check all that apply)
  - ( ) Cancer history If yes, date diagnosed? _____ Stage of cancer at diagnosis? _____
  - ( ) Diabetes history If yes, date diagnosed? _____ Last A1C reading? _____
  - ( ) Alcohol or drug abuse history If yes, date diagnosed? _____ Last date of in-treatment? _____
  - ( ) Heart history / condition Heart attack - date? _____ By-pass - how many vessels and date? _____
  - ( ) Sleep apnea If yes, date diagnosed? _____ On CPAP? _____
- Does the client have foreign travel plans? ( ) Yes ( ) No If yes, when, where and for what duration?: _____

  _____
- Does the client participate in aviation or hazardous activities? ( ) Yes ( ) No If yes, details: _____

  _____
- Has the client had a routine medical check-up within the past year? ( ) Yes ( ) No If yes, ( ) Normal ( ) Other _____
- List other illnesses or impairments: _____

  _____
- List any prescribed medications taken (include dosage and frequency): _____

  _____