

OAKTREE Brokerage www.oaktreeus.com (p) 800-842-9124 (f) 888-756-5954

## **CLASSIFICATION QUESTIONNAIRE**

Tobacco use in any form? ( ) Ye Recently stopped using tobacco? ( ) Ye Adverse motor vehicle report? ( ) Ye Any family history of disease? ( ) Ye Adopted? ( ) Yes  High blood pressure or elevated cholester  Ever been hospitalized? ( ) Ye  Any history of the following? (check all the company of the following) if yes, ( ) Cancer history If yes, ( ) Alcohol or drug abuse history If yes, ( ) Heart history / condition Heart	ss () No How m ss () No If yes, g ss () No If yes,	Anticipated Premium or Cla \$ Sup  Ch: lbs.  We form and frequency:  then:  ease detail:  t family member, age if livit disease, cancer)  f yes, current reading: BP	per-Preferred / Preferred / Super Standard / Standard ing or age at death and cause (heart disease,
ft in lb  Plan of Insurance (circle) / Amount Desired Term UL \$  Lost weight in last year? ( ) Ye  Tobacco use in any form? ( ) Ye  Recently stopped using tobacco? ( ) Ye  Adverse motor vehicle report? ( ) Ye  Any family history of disease? ( ) Ye  Adopted? ( ) Yes  High blood pressure or elevated cholester  Ever been hospitalized? ( ) Ye  Any history of the following? (check all the context of	s. ( ) Male ( )  ss ( ) No How m  ss ( ) No If yes, g  ss ( ) No If yes, p  onl? ( ) Yes ( ) No	Anticipated Premium or Cla \$ Sup  Ch: lbs.  We form and frequency:  then:  ease detail:  t family member, age if livit disease, cancer)  f yes, current reading: BP	per-Preferred / Preferred / Super Standard / Standard ing or age at death and cause (heart disease,
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Ever been hospitalized? ( ) You have a series of the following? (check all the following of the following? (check all the following) (check all the following) (check all the following) ( ) Cancer history If yes, ( ) Diabetes history If yes, ( ) Alcohol or drug abuse history If yes, ( ) Heart history / condition Heart			/ Chol
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Any history of the following? (check all the content of the following) (check all the content of the conte			HDL reading or ratio:
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( ) Diabetes history If yes. ( ) Alcohol or drug abuse history If yes. ( ) Heart history / condition Heart	nat apply)		
<ul><li>( ) Alcohol or drug abuse history If yes.</li><li>( ) Heart history / condition Heart</li></ul>	date diagnosed?		Stage of cancer at diagnosis?
( ) Heart history / condition Heart	date diagnosed?		Last A1C reading?
	date diagnosed?		Last date of in-treatment?
( ) Sleep apnea If yes.	attack - date?	By-pass - how	many vessels and date?
	date diagnosed?		On CPAP?
Does the client have foreign travel plans?	( ) Yes ( ) No	If yes, when, where and fo	or what duration?:
Does the client participate in aviation or h	azardous activities?	( ) Yes ( ) N	To If yes, details:
Has the client had a routine medical check List other illnesses or impairments:	x-up within the past y		To If yes, ( ) Normal ( ) Other
List other fillesses of impairments.			
List any prescribed medications taken (in			