



Client Health Questionnaire

CLIENT NAME	DATE OF BIRTH	NICOTINE USAGE	HEIGHT	WEIGHT
#1:		<input type="checkbox"/> NO <input type="checkbox"/> YES		
#2:		<input type="checkbox"/> NO <input type="checkbox"/> YES		

HEALTH STATUS & HISTORY

IN THE PAST 10 YEARS HAVE YOU RECEIVED MEDICAL ADVICE, TREATMENT, DIAGNOSIS OR CONSULTATION FOR ANY OF THE FOLLOWING CONDITIONS?

	CLIENT 1	CLIENT 2		CLIENT 1	CLIENT 2		CLIENT 1	CLIENT 2
Cancer (other than skin) *	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/Coronary Issues *	<input type="checkbox"/>	<input type="checkbox"/>	Digestive, stomach or intestinal issue	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's / Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes *	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
DWI, Alcoholism or Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Spine or Back Condition (ANY)	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's, Dementia or Memory	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Surgery or Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Strokes / TIAs	<input type="checkbox"/>	<input type="checkbox"/>
Amputation	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, COPD or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Injury due to fall/balance	<input type="checkbox"/>	<input type="checkbox"/>	Other condition causing crippling / disability	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions causing limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorder or Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Lung, Breathing Disorder or Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions requiring adaptive devices	<input type="checkbox"/>	<input type="checkbox"/>
Brain Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

* SEE PAGE TWO FOR REQUIRED MEDICAL INFORMATION NECESSARY TO ASSESS THESE ISSUES/CONDITIONS

Please provide details below for all medications taken (including over-the-counter) with the prescription name, reason prescribed, dosage and frequency. Additionally, please provide details for any questions answered "YES" along with information for any scheduled doctor visits, surgery, therapy or treatments

Authorization To Disclose Personal Medical Information

Under applicable state & federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), I give INERTIA / Advisor Services Group, and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or administration of insurance coverage on my behalf. The information used in accordance with this authorization may be redisclosed by INERTIA, and may no longer be protected by federal and state privacy laws.

- By signing this form, I agree to the release, disclosure, and sharing of my medical information by INERTIA and its agents and I relieve them from all liability having to do with that disclosure. This authorization will expire 24 months from the date of your signature. (Only valid for one year in CT, GA, IL, MA, MN, NC, NJ, OH, and OR). I am entitled to a copy of this authorization form and a digital copy of this authorization is as valid as the original.
- I have the right to revoke this authorization, in writing, at any time but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before receipt of the revocation notice.

Signatures of insured, applicant, annuitant, claimant or legal representative

Date

Applicable State(s)

Phone Number

Cardiac / Coronary Issues

Date of diagnosis/onset of chest pain: _____

Number of involved vessels _____

Dates and details of treatment and/or surgery (e.g., angioplasty, bypass, etc.)

Date of last testing (EKG, stress, stress echo, etc.): _____

Results: _____

Any symptoms since treatment/surgery: _____

Cancer

Name/diagnosis and location: _____

Date of diagnosis: _____

Stage/Grade/Metastasis: _____

Dates/details of treatment and/or surgery: _____

Any recurrence: _____

Date of last follow-up: _____

Diabetes

Date of diagnosis: _____ Type I or II

Treatment: Insulin Diet Medications

List insulin dosage and/or medications: _____

Date/result of last A1c: _____

Has proposed insured been diagnosed with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Insulin Reaction |
| <input type="checkbox"/> Cerebrovascular/Peripheral Vascular Disease | <input type="checkbox"/> Urine Protein/Microalbumin | |