

# Underwriting Questionnaire

## Depression/Anxiety

*Please answer all questions applicable to the client's medical history.*

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.  Term  Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Date(s) of initial and subsequent episodes of depression \_\_\_\_\_

What specific type(s) of depression has been diagnosed

- Bipolar disorder (mixed)  Dysthymia  Anxiety  
 Bipolar disorder (manic)  Major depression  Situational depression  
 Bipolar disorder (depressed)  Other \_\_\_\_\_

What medications are used to treat the condition

Type	Usual Quantity	Frequency of Use	How Taken	Dates: From - To

Has the client ever been hospitalized or gone to the Emergency Room for any depression/anxiety symptoms  Yes  No Date(s) \_\_\_\_\_

Has the client been treated with electric shock therapy (ECT)  Yes  No If yes, total number of ECT treatments \_\_\_\_\_

Date of first ECT treatment \_\_\_\_\_ Date of most recent ECT treatment \_\_\_\_\_

Has the client had (or been diagnosed with) any of the following conditions

- Alcohol / Drug abuse - Date of last use \_\_\_\_\_  
 Anorexia / Bulimia nervosa - Date diagnosed \_\_\_\_\_  
 Personality / Psychotic disorder - Date diagnosed and exact name of condition \_\_\_\_\_  
 Suicidal thoughts / attempts - Date of last such thought / attempt \_\_\_\_\_

The client is:  Working  On disability

List any other major health problems the client has: