Gastric Bypass Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

---

1. When did the proposed insured have gastric bypass surgery? _____

2. What was the proposed insured's weight prior to having surgery? _____

3. How long as the proposed insured maintained their current weight? _____

4. Did the proposed insured received treatment for medical conditions prior to the surgery that no longer require treatment? (e.g., diabetes, hypertension, heart disease) ___ Yes ___ No

   Please provide details including condition, treatment received and when treatment ended:

   _____

   _____

   _____

5. Is the proposed insured currently taking any medication? ___ Yes ___ No
   If yes, please provide the name, dosage and condition they are taking the medication for:

   _____

   _____

   _____

FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com