



Life Settlement Health Questionnaire

1) Insured 1: Height _____ Weight _____ Gain Loss in past year? _____ lbs
 Insured2: Height _____ Weight _____ Gain Loss in past year? _____ lbs

2) Within the past 10 years has either insured been treated or diagnosed by a physician as having:
 (Circle conditions to which "yes" answer applies and give details in number 3 below)

	<u>Insd 1</u>		<u>Insd 2</u>	
	Yes	No	Yes	No
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, stroke, convulsions, chronic headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Asthma, bronchitis, emphysema, tuberculosis, or other disorder of the lungs or respiratory system.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cancer, tumor or disorder of the prostate or reproductive organs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Arthritis, osteoporosis or other disorder of the muscles, skin or bones including joints or spine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Been on or advised to be on any medications or prescribed diet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Ever used or currently using tobacco or nicotine products (give details).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Ever been or is currently a member of any alcohol or drug rehabilitation program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Had a brother, sister or parent who had and/or died from cancer, diabetes, stroke, heart or kidney disease....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please describe any other health issues not mentioned above & list all medications: _____

Insured's Name	Question Number	Date of Diagnosis	Diagnosis – Medication Prescribed