

Pre-Qualification Questionnaire



INSTRUCTIONS

When to use the Pre-Qualification Questionnaire:

A pre-qualification questionnaire (also known as an informal application) can be utilized when an applicant:

- Has a complicated medical history, multiple existing health conditions or impairments, family hereditary conditions, or history of substance abuse.
- Is involved in high-risk activities/professions or sports (e.g., piloting an airplane, motor sports, skydiving, etc.).
- Has lifestyle issues that could impact ability to obtain coverage such as DUI/DWI, driver's license suspensions or revocations, felony conviction, probation or criminal charges, plans to travel to areas with health risks or political instability.
- Is applying for more than \$5,000,000 in coverage.

Benefits of using a Pre-Qualification Questionnaire:

An informal application can help determine if carriers are willing to underwrite an applicant with certain health or lifestyle risks, or narrow down coverage options before submitting a formal application to a carrier that is more likely to offer coverage.

When you submit the completed questionnaire to your FFS Case Manager, they will then submit it to multiple carriers (without any identifying information such as the applicant's name or SSN) to see which carriers may be willing to underwrite and offer a preliminary health rating based on the applicant's medical history and/or lifestyle. **However, it is important to note that a preliminary offer to an informal application does not guarantee a specific underwriting class or bind any insurance coverage.**

Each insurer has its own underwriting standards for what it considers to be acceptable risks. When reviewing an informal application, the insurer will determine if the applicant meets those standards for a preliminary offer. A binding offer is only available through submission of a formal application and full underwriting.

For best results when submitting the Pre-Qualification Questionnaire:

In order to make an informed decision, the carriers need as much information as possible to determine if they may be willing to extend a preliminary offer.

1. Complete this form as thoroughly and accurately as possible.
2. On the "**Blank Page for "Yes" Details to Health & Lifestyle Information,**" for any medical condition or impairment listed, make sure to include diagnosis, onset dates, type of treatment/medications, and the date of last consult with this provider, prescription names, dosages, how long taking medication, and any additional information that may be relevant.

These are the most common types of medical impairments and typical information needed.

- **High Blood Pressure:** Medications, how long taking medication, degree of control, last reading and date.
- **Diabetes:** Age diagnosed, type, last A1C reading, degree of control, treatment plan.
- **Heart Disease:** Type of heart disease, age diagnosed, medications.
- **Cancer:** Type and stage of cancer; treatment, if in remission, how long in remission.
- **Mental Health Disorder:** Medication, how long taking medication, hospitalization, suicidal ideation/attempts, how severe: mild, moderate, or major.

Pre-Qualification Questionnaire



- Use this form to submit an informal application to your FFS Case Manager.
- To Submit: Log into your FFS ABO (<https://www.ffi-leaders.com>), go to the Upload Docs section and select the “Pre-Qualification Questionnaire” option under “New Business” to attach your completed form.

AGENT INFORMATION

| | | |
|----------------|------|-----------------|
| Agent Name: | | FFS Agent Code: |
| Email Address: | Tel: | Date: |

PROPOSED INSURED

| | | |
|---|------------------------|---|
| Applicant's Name: | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Date of Birth: (mm/dd/yyyy) | Age: | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |
| Height: (ft/in) | Weight: (lbs) | |
| Any weight change in the last 12 months? If yes, lbs gained: _____ OR lbs lost: _____ | | |
| Speaks English: <input type="checkbox"/> Yes <input type="checkbox"/> No >> List Language _____ | | Resident State: |
| Annual Income: \$ | List source of income: | |
| Approx. Net Worth: \$ | | |

PROPOSED INSURED - COVERAGE TYPE

| | | |
|---|---|--------|
| Type of Insurance Coverage Requested: <input type="checkbox"/> Term <input type="checkbox"/> Whole Life <input type="checkbox"/> IUL <input type="checkbox"/> Final Expense | | |
| Amount of Insurance Being Applied For: \$ | Anticipated Monthly Premium Range: Min \$ | Max \$ |
| Have you ever had previous applications for insurance denied or postponed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If “Yes,” provide details (carrier, policy number, amount, denial reason, etc.) | | |

FAMILY HISTORY

| Have either of your parents or any siblings died prior to age 60 due to cancer, heart disease, stroke, diabetes or mental illness? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--------|--------|------------|--|
| Age | Mother | Father | Brother(s) | Sister(s) |
| Current Age or Age at Death | | | | |
| Year and Cause of Death | | | | |

NICOTINE

| |
|--|
| In the last 5 years, have you used cigarettes, tobacco, chew, pipe, snuff, e-cigarettes or any product containing nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If “Yes,” provide type, frequency of use, amount used and date of last use. |

HEALTH & LIFESTYLE INFORMATION

Please answer the following questions: **(use the blank page to provide details to any "Yes" answer)**

| | |
|--|--|
| 1a. In the last 2 years, have you flown an aircraft as a pilot or student pilot, participated in rock or mountain climbing, racing of any motor-powered land vehicle or watercraft, scuba diving, mixed martial arts or aeronautics (including hang gliding, sky diving, base jumping, parachuting, ultralight, soaring and ballooning). Do you intend to do so within the next 2 years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1b. If "Yes," provide details. | |
| 2a. In the last 5 years, have you pleaded guilty to or been convicted of reckless driving or driving under the influence of alcohol or drugs, had a driver's license suspended or revoked or had more than one moving violation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2b. If "Yes," provide details. | |
| 3a. Have you ever pleaded guilty to or been convicted of a felony, are you currently on probation or do you currently have any criminal charges against you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3b. If "Yes," provide details. | |
| 4a. In the last 5 years, have you used marijuana in any form? Have you ever used any illicit drugs or used habit-forming prescription drugs, except as prescribed by a licensed member of the medical profession? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4b. If "Yes," provide details. | |
| In the last 10 years, have you been diagnosed, treated, been given medical advice or received follow up by a licensed member of the medical profession for any of the following conditions? Please use the blank page to provide details to any "Yes" answer. | |
| 5a. High blood pressure or high cholesterol, coronary artery disease, stroke, mini-stroke, or TIA, chest pain or discomfort, angina, heart attack, heart murmur, valve disorder, peripheral vascular disease, atrial fibrillation, aneurysm, or any other disease, disorder or defect of the heart, arteries or veins? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5b. If "Yes," provide details. | |
| 6a. Diabetes, high blood sugar, sugar in urine, glucose intolerance, thyroid disorder, sleep apnea, any disease or disorder of the kidneys, bladder or prostate, or findings of sugar, protein or blood in your urine? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6b. If "Yes," provide details (for diabetes explain if type 1 or 2, insulin dependent and is the condition controlled) (for Sleep apnea: are you compliant using CPAP). | |
| 7a. Any disorder or disease of the digestive system, including ulcerative colitis, Crohn's disease, gastrointestinal bleeding, Barrett's esophagus, acid reflux, pancreatitis, or any other inflammatory intestinal or bowel disorder, Hepatitis, cirrhosis, fatty liver, colitis, or any other disorder or disease of the stomach, liver or digestive system? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7b. If "Yes," provide details. | |
| 8a. Cancer of any type, including basal cell or squamous cell carcinoma of the skin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8b. If "Yes," provide details. | |
| 9a. Seizures, fainting, Alzheimer's, multiple sclerosis, Parkinson's disease, or any other disorder or disease of the brain or nervous system? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9b. If "Yes," provide details. | |
| 10a. Depression, anxiety, bi-polar disorder, or any psychiatric, emotional, or mental health disorder or disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10b. If "Yes," provide details: (if on multiple medication for depression/anxiety) | |

CURRENT MEDICATIONS

| Are you presently taking any medication(s), including over-the-counter medication(s), supplements or homeopathic remedies? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
|--|--|-------------------|
| List all medications (including over-the-counter drugs) which you are currently taking. Attach an additional page if more space is needed. | | |
| Medication | Dosage and Frequency | Reason for Taking |
| | | |
| | | |
| | | |
| | | |
| | | |

CITIZENSHIP & TRAVEL

| | |
|---|--|
| Are you a US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No >> List the type of visa, green card status and length of time in US | |
| Do you have any future plans to live or travel outside the US? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes," provide purpose, cities, countries, frequency, and duration of trips. | |

Agent Section:

If your client answers "Yes" to any of the highlighted conditions in the above questionnaire, please consult your FFS case manager so they can give you a quick quote to see if your client would qualify for insurance.

When submitting an actual policy application, attach a cover letter or add remarks to the application that explains a client's health, lifestyle or financial situation. The more information you can provide to the carrier underwriters so that they can better understand your client and their needs, the more likely you will receive a favorable offer.

Just a reminder that for juvenile cases, the parents need more coverage and in most circumstances the siblings need to have equal coverage. A cover letter would be helpful to your case in explaining the reason for the insurance, the amount on the parents and why other siblings do not have coverage or why the amounts are different.

If writing multiple applications on the same individual or on multiple family members in the same household (spouses or children), please attach a cover letter informing the carrier so the same underwriter can be assigned to all of the cases.

Please check to make sure you are licensed and appointed in the state you are writing the business. Also, check to make sure you have completed all necessary training before signing the application, if applicable.

Blank Page for “Yes” Details to Health & Lifestyle Information