



BEST VALUE INSURANCE AGENCY, INC.

1700 S. Campbell, Suite C
Springfield, MO 65807
Office: (417) 863-1096
Fax: (417) 863-8640
bviamkt@swbell.net

www.einsureforless.com

Critical Illness Insurance Questionnaire

Personal Information

Name: _____ DOB: ___/___/___
Height: _____ Weight: _____ Smoker? Yes No
Address: _____
Phone Number(s): _____ E-mail Address: _____
Occupation: _____ Income: \$ _____

Health History

- During the past 10 years, has the proposed insured:
 - Had surgery? If yes, explain: _____
 - Been hospitalized? If yes, explain: _____
- Has any proposed insured's natural parents, brothers or sisters been diagnosed prior to age 60 with any of the following conditions?

Diabetes	Heart Disease	Stroke
Kidney Disease	Cancer (other than skin cancer)	

If yes, who was it? _____ Outcome: _____ Age at time of diagnosis: _____
- Within the past six months, has the person proposed for insurance taken any of the following:
 - Prescription Medications – If yes, what is the medication(s) name? _____
Dosage/Frequency? _____ Reason for med(s)? _____
 - Over the Counter Medications – If yes, what is the medication(s) name? _____
Dosage/Frequency? _____ Reason? _____

- Has the proposed client ever received medical care for the following:

Alcoholism	Eye or Ear Disorder	Psych./Emotional/Nervous Condition
Anemia	Heart disease	Paralysis or Numbness
Arthritis	High Blood Pressure	Prostate Disorder
Back Disorder	Kidney Disorder	Respiratory Disorder
Kidney Disorder	Respiratory Disorder	Breast Disease/Disorder
Cancer	Major Organ Transplant	Tumor, Polyp or Growth
Diabetes	Multiple Sclerosis	Digestive Disorder

Policy Information

Base Policy Amount: \$ _____ Disability Rider: Yes No
Accidental Death & Dismemberment Benefit Rider: Yes No Amount: \$ _____
Hospital Confinement Benefit Rider: Yes No



HEALTH • LIFE • SENIOR PRODUCTS
ANNUITIES • RETIREMENT ACCOUNTS

