SERRA BENEFITS
& Insurance Services

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DISABILITY INSURANCE QUESTIONAIRE

Applicant Name:
Phone:
Address:
Date of Birth:
Spouses Name:
Male or Female (Circle)
Occupation:
Gross Income:
Height/Weight:
Smoker or Non-Smoker (Circle)
Other:
Frequency Per Day:

1. Have you ever been diagnosed or treated for the following? If yes, please provide details below. (Circle)

Hypertension/HBP	Cancer	Diabetes
Cholesterol	Heart Disease	

2. Is there any family history of Cancer? Yes or No (Circle) If yes, please include family member, age of onset, and age of death.

_____

3. Is there any family history of heart disease? Yes or No (Circle) If yes, please include family member, age of onset, and age of death.

_____

4. Are you on any medication(s)? Yes or No (Circle) If yes, please detail name(s) and dosage(s).

_____

5. Do you participate in any of the following activities? (Circle)

Aviation	Mountain Climbing	Scuba Diving	Hang Gliding
Race Car Driving	Sky Diving	Competitive Skiing	Other

6. Date you lasted cosulted your physician and reason for visit:

_____

Additional Comments:_____