LIFE SETTLEMENT QUESTIONNAIRE

Insurance company_____Policy number _____

Insured Name_____

Height_____Weight_____Social security number_____Date of birth_____ Gender_____

MM/DD/YYYY

1. Do you live in one of the following? (assisted living facility, skilled nursing facility or nursing home, other)

_____ If yes, approximately how long have you lived there?

_____

2. Do you require assistance to perform any of the following activities? *(meal planning, taking medication, shopping, walking, bathing, dressing)*

If yes, provide details regarding why assistance is needed _____

3. After you fall asleep at night, on average, how many times (if any) do you typically get up? _____

4. Do you drive? If no, provide year and reason you stopped driving _____

_____

5. Approximately how often do you see your primary care physician? _____

6. Approximately how often do you see specialists, such as a cardiologist or orthopedist? _____

7. Are you currently choosing not to see doctor(s) or choosing not to follow a doctor's instruction? If yes, provide details

_____

8. Has your weight changed in the last year? If yes, provide details _____

9. Do you engage in sports or regular exercise? If yes, provide type and frequency _____

10. Have you ever smoked cigarettes? _____

If you currently smoke or previously smoked, provide number of years_

_____cigarettes per day _____

If you quit smoking, approximately how many years ago did you quit? _____

11. Do you use any other form of tobacco or nicotine? _____

If yes, provide type and frequency _____

12. Do you drink alcoholic beverages? _____

If yes, provide type and frequency _____

Have you ever been diagnosed with OR treated for any of the following conditions?
(*Please check all that apply and provide details at the end of section four on page three.)*

1. Disease or disorder of the heart?

_____

_____

2. Circulatory or Blood Vessel Disorder?

3. Cancer? (not including non-melanoma minor skin cancer)

4. Neurological Disorder?

5. Mental or Nervous Disorder?

6. Disease or Disorder of the Digestive System?

7. Infectious Disease? (other than common cold or flu)

8. Disease or Disorder of the Lungs or Respiratory System?

9. Genitourinary Problems, Disease or Disorder?

10. Abnormality of the Blood, Platelets or Blood Forming Organs?

11. Bone, joint or nerve Abnormality, Injury or Accidental Fall?

12. Immune System Disorder?

13. Alcohol and Drug Use?

14. Have you ever had a transplant of any organ or tissue, been diagnosed with, been treated for, had surgery, or are currently being treated for any other disease or disorder, or had an accident or injury not previously listed?

_____

_____

15. Other Conditions Not Listed?

_____

_____

16. Health Screen History (if known)

Blood Pressure _____ Blood Tests: Cholesterol _____ Blood Sugar _____ Ejection Fraction _____

For any condition checked above, please provide full details including diagnosis, date of diagnosis, type of treatment(s) received, date last treated, results and additional details. *(Please attach additional page(s) as necessary.)*

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY

Type of treatment received _____ Date last treated _____ MM/DD/YYYY

Mother	_____	_____	_____	
Father	_____	_____	_____	
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Sibling	_____	_____	_____	Gender_____
Spouse	_____	_____	_____	Gender_____

Results _____

Family History (Include full and half siblings.)

	Age, if living	Age at death, if deceased	Cause of death

Prescription Medications

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Physician Information

1. Primary Care Physician

Name_____ Phone _____

Address_____ City_____ State_____ ZIP_____

Approximate date of last visit_____ Reason for last visit _____
MM/ /YYYY

2. Specialty Care Physicians

List those who have treated you in the last five years. *(Please attach additional page(s) as necessary.)*

Name_____ Phone _____

Physician Specialty _____

Address_____ City_____ State_____ ZIP_____

Approximate date of last visit_____ Reason for last visit _____
MM/ /YYYY

Name_____ Phone _____

Physician Specialty _____

Address_____ City_____ State_____ ZIP_____

Approximate date of last visit_____ Reason for last visit _____
MM/ /YYYY

Name_____ Phone _____

Physician Specialty _____

Address_____ City_____ State_____ ZIP_____

Approximate date of last visit_____ Reason for last visit _____
MM/ /YYYY

Policy Information

Carrier:_____ Benefit:_____ Term or Permanent?_____

Annual Premiums to carry coverage to age 100: _____

Rate Class: _____

Please send completed forms to: andrew@carylevinson.com or fax to 954-746-9535.
Thank you,