PTAdvantage℠ Underwriting Questionnaire

Please fax back to Reliable Financial Group : 1-877-921-1755

(Please Print Clearly)

Agent's Name: _____ Phone: _____

Agent Address: _____

Suite No.: _____ City: _____ State: _____ Zip: _____

Fax: _____ Email: _____

Applicant's Name: _____
(First) (Middle Initial) (Last)

State: _____ Birth date: _____ Age: _____ Height: _____ Weight: _____ Sex: _____
(Month) / (Day) / (Year) (Ft./In.) (Lbs.)

Smoker: ☐ Yes ☐ No Premium Commitment: $ _____ Daily Benefit Amount: $ _____

Waiting Period: 30 60 90 180 Days (circle one) Benefit Period: 1 2 3 4 5 6 Years (circle one)

Medical Profile

Yes ☐ No ☐

1. Does your client currently have, or have you been medically diagnosed as having any of the following conditions?

- Acquired Immune Deficiency Syndrome (AIDS)
- HIV Positive
- Organic Brain Syndrome
- Down's Syndrome
- ALS (Lou Gehrig's Disease)
- Chronic Memory Loss
- Muscular Dystrophy
- Cerebral Palsey
- Alzheimer's Disease
- Senility/Dementia
- Huntington's Chorea
- Psychosis/Schizophrenia

If any of the questions in this section are answered "YES," THE CLIENT WILL NOT QUALIFY. Otherwise, please continue.

Yes ☐ No ☐

1. Does your client currently need the assistance or supervision of another person in performing any of the following activities:
Moving in/out of bed or chair; Bathing; Dressing; Toileting; Bowel/Bladder Control; Eating?

2. Within the past five (5) years has your client: received medical advice or treatment, taken any medications, diagnosed, been confined to a convalescent care facility, hospital, or nursing facility, or professional for any of the following conditions: (If "YES," please circle any that apply).

☐ ☐ A.Paralysis; Stroke; Transient Ischemic Attack (TIA); Hodgkin's Disease; Leukemia; Lymphoma; Cancer, Heart Surgery; Angioplasty; Heart Attack; High Blood Pressure; Congestive Heart Failure (CHF); Disabling Back or Spine Injury?

☐ ☐ B. Emphysema; Shortness of Breath; Fainting Spells; Blacking Out; Injury due to Falls or Imbalance?

☐ ☐ C. Brain Disorder; Mental Illness; Depression; Alcoholism; Drug Addiction?

☐ ☐ D. Epilepsy; Seizures; Convulsions; Tremor; Diabetes; Skin Ulcers?

☐ ☐ E. Multiple Sclerosis; Osteoporosis; Arthritis; other conditions causing Crippling or Limited Motion?

3. During the past three (3) years have you:

☐ ☐ A. Been medically advised to have surgery which has not been performed?

☐ ☐ B. Consulted with or been treated by a health professional for any reason not previously stated (excluding eye doctors, podiatrists, chiropractors, and dentists)?

☐ ☐ C. Received home care; used an adult day care facility; been medically advised to enter a nursing home; or been confined to a hospital or other health care facility? (If "YES," please circle any that apply).

DETAILS FOR "YES" ANSWERS TO ANY PART OF QUESTIONS 1, 2 AND 3 Attach additional sheets with extra medical information

DESCRIBE SICKNESS, INJURY and TREATMENT If surgery performed – state type	DATES OF Symptoms and/or Treatment From	To	DEGREE OF RECOVERY	Medication(s) Taken