## **Underwriting Questionnaire**

## **Gastric Bypass**

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Producer Name	Phone		Date	_ \
Client Name	Date of Birth			
☐ Male ☐ Female Face Amount		Max Premium \$	/yr.	
☐ Term ☐ Permanent Has the client e	ver used any form of tol	pacco (cigarettes, cigar	s, pipe, snuff, etc.)?	□Yes □No
requency	Date of last use		Type	
pate of procedure	ype of procedure (e.g. g	astric bypass, banding,	etc.)	
Veight prior to procedure Current v	weight Has v	weight loss been stable	e/maintained □Ye	s 🗆 No
leight				
□ Hemorrhage □ □ Obstruction □ □ Perforation □ Leaks □ □ Abnormal liver function studies □ □ Hypoglycemia □ □ Nutritional deficiencies □ Vomiting or nausea □ □ Change in bowel habits/diarrhea due to □ Failure to lose weight □ □ Problems retaining weight □ □ Dumping syndrome	o dietary modifications			
Any history, past or present, of associated chron cardiovascular disease? □Yes □No If yes,		etes, hypertension, hyp	oerlipidemia, obstru	ctive sleep apnea, or
Name of Medication (prescription or other	wise) Date	s Used Qu	uantity Taken	Frequency Taken

List any other major health problems the client has:



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