Return to - jim@uswolfe.com or Fax to 815-377-3556

LIVER QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. What is your actual diagnosis?

2. When were you diagnosed?

3. What were your first symptoms?
   Details:

4. Please provide on the back of this page dates, tests, and results that have been completed to give you this diagnosis.

5. Indicate your current liver function levels, if known?

6. Have you ever been diagnosed with any of the following (please circle all that apply)?
   Hepatitis Crohns Ulcerative Colitis Alcoholism Drug Abuse
   *If any of the above are circled, please complete the additional questionnaire(s).

7. Have you ever had a gall bladder problem? Yes No
   Details:

8. Have you ever had any surgeries? Yes No
   Dates & details:

9. Are you on any medications(s)? Yes No
   Name(s) and dosage(s):

10. Name, address & phone number of your physician(s) and date last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____