

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

TOBACCO 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. Which of the following tobacco products do you or have you used (please circle all that apply)?

Cigarettes	Amount: _____	Period of time used: _____
Cigars	Amount: _____	Period of time used: _____
Pipe	Amount: _____	Period of time used: _____
Chewing Tobacco	Amount: _____	Period of time used: _____
Marijuana*	Amount: _____	Period of time used: _____
Other:	Amount: _____	Period of time used: _____

***Please complete the Drug Questionnaire.**

2. If you are no longer a user of tobacco products, when and why did you quit?

When: _____

Why: _____

3. Are you taking any medications? Yes No

Name(s) and dosage(s): _____

4. 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: _____