The Producers Group's

Alcohol Usage Questionnaire

Agent:______________________ Phone:______________ Fax:______________

Client:______________________ DOB: ______________ ☐ Male ☐ Female

Product/Face Amount:______________________ Height:______________ Weight:______________

TOBACCO/NICOTINE USE (past or present): ☐ YES*** ☐ NO

****Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:*

Do you presently consume alcohol beverages?

☐ Yes ☐ No *If "no", date of last drink:* ______________________

Quantity & Type Consumed *(Present Use)*

CURRENT USE	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Did you ever consume substantially more alcohol than at present?

☐ Yes ☐ No

Please outline details as to PAST alcohol use below:

PAST USE	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Have you ever been advised by an MD or other medical profession to limit your alcohol consumption, OR have you ever consulted a doctor or received any form of treatment/therapy related to alcohol use?

☐ Yes ☐ No

If yes, please provide details, including dates, as to any advice, therapy and/or treatment relative to alcohol use:

Are you currently, or have you ever been active in A.A. or similar recovery/support groups?

☐ Yes ☐ No

If yes, please provide brief summary of participation:

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Have you ever been arrested for driving under the influence of alcohol or encountered any other legal consequences related to alcohol use?
☐ No ☐ Yes

If yes, please Provide details *(date, charges, disposition of case, current status, etc.)*

FAMILY HISTORY: *(Family history may be a factor in determining rate class)* Is there a family history *(parent or siblings)* of the following conditions/disease onset prior to age 60:

Cardiac Disease ☐ YES ☐ NO Diabetes ☐ YES ☐ NO

Stroke or TIA ☐ YES ☐ NO Cancer ☐ YES ☐ NO

Please provide details for any "YES" response below (write additional comments in email if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED *(list age at time of death)*
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

MEDICATIONS - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Are you currently employed or capable of being employed?
☐ Yes ☐ No

Do you have any other significant health issues or medical conditions not outlined or mentioned on this form? (Complete additional questionnaires, as indicated)

☐ Condition(s) - List treatment and current status:

☐ NONE - NO other medical conditions or health issues.

Alcohol Usage Questionnaire

Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.

Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?