AGENTS INSURANCE SERVICES of AMERICA, Inc.
Email: to UndSolutions@cs.com or Fax to: (760) 435 9703
Phone: (760) 435-9702

Gastric Bypass Questionnaire

Name []Male [] Female Age Date of Birth

Tobacco Use [] No []Cigarettes [] Other tobacco Date quit?

State Amount of Insurance Type of Insurance

Occupation/Source of income:

Gastric Bypass

Date of Gastric Bypass: _____ Type of Bypass _____

Current Heigth _____ Current Weight _____

How long have you maintained this weight? _____

Weight prior to Gastric Bypass _____

Any medication or supplements prescribed? _____

General Questions:

1. Do you have any other major health problems? [] No [] Yes – Details:

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2. List all medications:

Agent Name:

Address: **City:** **State:** **Zip:**

Phone: **Fax:** **Email:**

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance