

310 S. Dale Mabry Hwy, Ste 210 Tampa, FL 33609 Phone (813) 875-6331 Fax (813) 875-7331

## **Depression Underwriting Questionnaire**

Email Address	Agent Name			Phone	Phone	
Sex	Email A	ddress				
Ever use nicotine products?	Applicant Last Name			Date of Birth	Date of Birth	
Date last used Frequency per month	Sex			Height/V	Height/Weight//	
Product Applying for:   Term   Universal   Face Amount    1. Have you been diagnosed with:   Depression   Anxiety 2. Describe your condition:   3. Date of first symptoms:   4. Please indicate the number of episodes:   Date of last episode:   5. Have you been hospitalized for psychiatric treatment?   No   Yes; please give dates and length of stay  6. Do you have a history of any of the following associated conditions:   Personality Disorder   Suicidal thought/attempt   Psychotic Disorder   Substance abuse (alcohol or drugs)- complete respective questionnaire   Other psychiatric disorder:   7. Is the client currently working?   No   Yes; please list occupation:   8. Has any time been lost from work as a result of this condition?   No   Yes; give details  9. Are you disabled?   No   Yes  10. Please list all medications:   Name of Medication   Dosage   Reason   11. Please list name of physicians and date last seen:	Occupation			Ever use nico	Ever use nicotine products?	
Product Applying for:	If yes, s	elect type : Cigarettes Ciga	r 🗌 Chewing to	bacco 🗌 Other:		
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2. Describe your condition:  3. Date of first symptoms:  4. Please indicate the number of episodes:  5. Have you been hospitalized for psychiatric treatment? No Yes; please give dates and length of stay  6. Do you have a history of any of the following associated conditions:  Personality Disorder Suicidal thought/attempt Psychotic Disorder Substance abuse (alcohol or drugs)- complete respective questionnaire Other psychiatric disorder:  7. Is the client currently working? No Yes; please list occupation:  8. Has any time been lost from work as a result of this condition? No Yes; give details  9. Are you disabled? No Yes  10. Please list all medications:  Name of Medication Dosage Reason	Produc	t Applying for: 🗌 Term 🔲 Uni	versal	Face Am	ount	
10. Please list all medications:  Name of Medication  Dosage  Reason  11. Please list name of physicians and date last seen:	<ol> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> <li>6.</li> </ol>	Date of first symptoms:  Please indicate the number of episodes:  Have you been hospitalized for psychiatric treatment?  No Yes; please give dates and length of stay  Do you have a history of any of the following associated conditions:  Personality Disorder  Suicidal thought/attempt  Psychotic Disorder  Other psychiatric disorder:  Is the client currently working?  No Yes; please list occupation:				
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<u></u>		Name of Medication	Dosage	Reason		
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realite of proposition   Location   Date last seem	ſ	Name of physician	Location		Date last seen	
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Please fax this form to MRW Financial Inc. 813-875-7331 or email to marie@mrwfinancial.com