



DRUG USAGE QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
 Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
 Broker's Name: _____ Face Amount: _____
 BGA: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

- Indicate any of the following drugs you are currently using or have used in the past:

| | | | | |
|--------------------------------------------|----------------------------------------|------------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Opium derivatives | <input type="checkbox"/> Heroin | <input type="checkbox"/> Morphine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Phenobarbital | <input type="checkbox"/> Amytal | <input type="checkbox"/> Seconal | <input type="checkbox"/> Nembutal |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Hashish | <input type="checkbox"/> Cannabis | | |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Benzedrine | <input type="checkbox"/> Dexedrine | <input type="checkbox"/> Methedrine | |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Crack | <input type="checkbox"/> Any derivatives | | |
| <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> LSD | <input type="checkbox"/> DMT | <input type="checkbox"/> Mescaline | <input type="checkbox"/> Peyote |
| <input type="checkbox"/> IV drug use: | | | | <input type="checkbox"/> Psilocybin |
| <input type="checkbox"/> Other: | | | | |
- Please note details on the above mentioned:

| | |
|------------|-----------------|
| Type: | Quantity: |
| Frequency: | Date last used: |
| Type: | Quantity: |
| Frequency: | Date last used: |
| Type: | Quantity: |
| Frequency: | Date last used: |
| Type: | Quantity: |
| Frequency: | Date last used: |
- Do you consume any alcohol? No Yes, Details: _____
- Have you ever suffered from any liver disorder (i.e., enlarged liver, elevated Liver Function Tests) due to drug use? No Yes, Details: _____
- Have you ever been confined to bed, or lost your job due to your connection with drugs?
 No Yes, Details: _____
- Have you ever been arrested or charged in connection with the drugs?
 No Yes, Details: _____
- Have you had any moving traffic violations in the last 5 years? No Yes, Details:

| | | | |
|---------------------------------------------------------------|---------|--------------------|----------------------------------------------------------|
| <input type="checkbox"/> Violations | Number: | Type: | Dates: |
| <input type="checkbox"/> Accidents | Number: | Were you at fault? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> License suspensions or revocations : | Dates | | |
| | Reasons | | |
- Are you on any medication(s)? No Yes, Name(s) and dosage(s): _____
- Date you last consulted your physician: _____
- Have you ever received treatment or counseling, consulted or been advised by a doctor, medical facility, or support group (Alcoholics Anonymous, Narcotics Anonymous, etc.) because of your drug use?
 No Yes, Name and address(es) of any doctor(s), hospital(s), and/or treatment center(s): _____

Underwriter's Notes: _____

Date: _____ Proposed Insured's Signature: _____