



Diversified Marketing Group, Inc. 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"/> Psilocybin
<input type="checkbox"/> IV drug use:				
<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 _____ FAX: 513-321-1360