



Diversified Marketing Group, Inc.
GASTRO/INTESTINAL 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:

1. Date you first experienced symptoms?
2. What is your actual diagnosis?
3. Date of your last attack?
4. How often do you have attacks?
5. Are the attacks becoming more frequent? Yes No
6. Do you experience any of the following?
 Black stools Vomiting Bleeding Relieved by eating
7. Have you had any weight loss in the past 6 months? No Yes, Amount: _____
8. Have you had any surgery(ies) for this disease?
 No Yes, Date(s): _____
Details: _____
9. How often do you have a full work-up for your gastro/intestinal problem?
10. What tests or procedures does the complete work-up include?
11. Are you on any medication(s)? No Yes, Details: _____
12. Date you last consulted your physician: _____
13. Name and address of your physician(s): _____

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____