Diversified Marketing Group, Inc.
LIVER 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. What is your actual diagnosis?

2. When were you diagnosed?

3. What were your first symptoms?

4. Please indicate dates and tests that have been completed to give you this diagnosis?

   Date: Test:

   Results:

   Date: Test:

   Results:

   Date: Test:

   Results:

   Date: Test:

   Results:

5. Indicate your current liver function levels, if known?

6. Have you ever been diagnosed with any of the following, if yes provide details and complete the additional relative questionnaire(s):

   ☐ Hepatitis ☐ Crohns ☐ Ulcerative colitis ☐ Alcoholism ☐ Drug Abuse

   Details:

7. Have you ever had a gall bladder problem? ☐ No ☐ Yes, Details:

8. Have you ever had any surgeries? ☐ No ☐ Yes, Details:

   Date(s):

9. Are you on any medication(s)? ☐ No ☐ Yes, Name(s) and dosage(s):

10. Date you last consulted your physician:

11. Name and address of your physician(s):

Underwriter's Notes:

Date: ___________ Proposed Insured's Signature ______________________________

FAX: 513-321-1360