



Diversified Marketing Group, Inc. TOBACCO SUMMARY

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. Which of the following tobacco products do you or have you used?

- | | | |
|--|---------------|----------------------------|
| <input type="checkbox"/> Cigarettes | Amount: _____ | Period of time used: _____ |
| <input type="checkbox"/> Cigars | Amount: _____ | Period of time used: _____ |
| <input type="checkbox"/> Pipe | Amount: _____ | Period of time used: _____ |
| <input type="checkbox"/> Chewing tobacco | Amount: _____ | Period of time used: _____ |
| <input type="checkbox"/> Marijuana * | Amount: _____ | Period of time used: _____ |
| <input type="checkbox"/> Other: | Amount: _____ | Period of time used: _____ |

*** Please complete the Drug Questionnaire.**

2. If you are no longer a user of tobacco products, when and why did you quit?

When: _____, Why: _____

3. Are you on any medication(s)? No Yes, Details: _____

4. Date you last consulted your physician: _____

5. Name and address of your physician(s): _____

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____