HEIRMARK PRELIMINARY QUESTIONNAIRE

Since 2007	7005 S. Edgerton Road Suite 101 Cleveland, OH 44141	P:(440) 630-9400 F: (440) 630-9401

NOTE: This information is for official and confidential use only and will not be released to unauthorized persons

PERSONAL

1. NAME *(First, Middle, Last)*		2. SSN	3. DATE OF BIRTH	4. SEX ☐ M ☐ F
5a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*		5b. CITY (Name)	5c. STATE	5d. ZIP CODE
5e. YEARS AT ADDRESS	5f. PERSONAL EMAIL	5g. HOME PHONE	5h. CELL PHONE	
6a. EMPLOYER NAME	6b. OCCUPATION/TITLE	6c. WORK EMAIL	6d. WORK PHONE	
6e. EMPLOYER ADDRESS		6f. CITY	6g. STATE	6h. ZIP CODE

7. PLACE OF BIRTH (state/province, country)	8a. DRIVER'S LICENSE NUMBER	8b. STATE OF ISSUE

9. **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

10. **Are you a US Citizen? (If No, please provide copy of Visa, green card, etc.)** ☐ Yes ☐ No

11. **Do you intend to travel outside of the U.S. or Canada in the next 12 months?** ☐ Yes ☐ No
(If yes, please provide details below):

City/Country	Dates	Purpose	Accommodations (hotel/home etc.)

12. **Are you a senior foreign political figure or an immediate family member or close associate of a senior foreign political figure?** *(If "Yes" please provide details on page 3)* ☐ Yes ☐ No

13. **Do you or have you ever used tobacco or any other nicotine products?** ☐ Yes ☐ No

(cigarettes, cigar, pipe, chewing tobacco, snuff, nicotine gum or patch)? *If yes, indicate:*

a) **Type of tobacco/nicotine product:** _____

b) **Frequency (i.e packs per day/week):** _____

c) **If tobacco/nicotine product has been discontinued indicate date/product last used:** _____

MEDICAL

14. **Please list your height and weight:** ***Height_____ft_____in Weight_____lbs***

15. **Please provide details of all physicians seen in the last 5 years:**

Physician	Name and Address	Phone#	Date/Reason of Last Visit
Primary Care Physician			
Additional Physicians (i.e. Cardiologist, OBGYN, Urologist, Dermatologist, Gastroenterologist, etc.)			
Any inpatient hospital stay or visits to the Emergency Room			

16. **Are you currently taking any medications?** ☐ **Yes** ☐ **No**

If yes, please provide details below:

Name	Dosage	Name	Dosage

17. **Have you or a member of your household come into close contact with anyone known to have tested positive for COVID-19 within the past 30 days?** ☐ **Yes** ☐ **No**

18. **Have you ever had or been treated for any of the following?** ***(Provide details on page 3):*** ☐ **Yes** ☐ **No**

☐ **stroke** ☐ **cancer** ☐ **diabetes** ☐ **sleep apnea**

☐ **heart attack** ☐ **heart disease** ☐ **depression**

19. **Have you been advised by a physician that you may require hospitalization, surgery or treatment for any reason within the next 60 days?** ***(If yes please provide details on page 3)*** ☐ **Yes** ☐ **No**

20. **In the last 5 years, have you been unable to work, unable to attend school or been disabled for two weeks or more?** ***(If yes, please provide details on page 3)*** ☐ **Yes** ☐ **No**

21. **Have you ever been diagnosed by a licensed member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) or any immune deficiency disorder?** ☐ **Yes** ☐ **No**

22. **Family history:**

	Age	Living (Current state of Health)	Deceased (Age at Death/Cause)
Father			
Mother			
Brothers			
Sisters			

23. **Have you ever:**

a) **Used any form of marijuana? Type_____ Date of last use_____ Frequency _____** ☐ Yes ☐ No

b) **Used stimulants, hallucinogens, narcotics or any controlled substance other than prescribed by a physician?** ☐ Yes ☐ No

c) **Received, or been advised to receive, treatment or counseling for alcohol or drug use?** ☐ Yes ☐ No

d) **Been a member or ever been advised to become a member of any self-help group such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?** ☐ Yes ☐ No

24. **In the last 5 years, have you engaged in or do you now intend to engage in any hazardous activity (i.e. licensed/student pilot, scuba diving, auto racing, hang gliding, etc.)?** ☐ Yes ☐ No

25. **Within the past 5 years, have you:**

a) **Been convicted of a felony, arrested, imprisoned for any reason or are any criminal charges now pending?** ☐ Yes ☐ No

b) **Had a driver's license suspended, restricted or revoked?** ☐ Yes ☐ No

c) **Ever been charged with two or more moving violations? If yes, advise type of violation and reason for license denial, suspension or revocation.** ☐ Yes ☐ No

d) **Had any alcohol or drug related driving offense?** ☐ Yes ☐ No

e) **Been involved in two or more auto accidents?** ☐ Yes ☐ No

26. **Do you have any liens, lawsuits or bankruptcies pending?** ☐ Yes ☐ No

PLEASE PROVIDE DETAILS FOR ANY QUESTIONS THAT WERE ANSWERED YES

This form is NOT a formal application for life insurance. This Private Preliminary Inquiry is used exclusively by Heirmark to informally investigate your insurability through our proprietary and confidential process. It will be used to gather specific information for a proposed insured's medical history and other factors that may impact underwriting and rating classification. Completed forms can be returned via email to lturco@heirmark.com, fax (440) 630-9401, or mail 7005 S. Edgerton Rd., Ste. 101, Cleveland, OH 44141.