



# IMS ASSOCIATES

A LIFE SETTLEMENT BROKERAGE

## Life Settlement Health Questionnaire

1. (a) Insured 1: Height \_\_\_\_\_ Weight \_\_\_\_\_  Gain  Loss in past year? \_\_\_\_\_ lbs.  
 Insured 2: Height \_\_\_\_\_ Weight \_\_\_\_\_  Gain  Loss in past year? \_\_\_\_\_ lbs.

2. Within the past 10 years has either insured been treated or diagnosed by a physician has having:  
 (**Circle** conditions to which “yes” answer applies and give details in number 4 below.)

	Insd. 1		Insd. 2	
	Yes	No	Yes	No
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, stroke, convulsions chronic headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Asthma, bronchitis, emphysema, tuberculosis or other disorder of the lungs or respiratory system.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cancer, tumor or disorder of the prostate or reproductive organs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Arthritis osteoporosis or other disorder of the muscles, skin or bones including joints or spine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Been on, or advised to be on any medication or prescribed diet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Ever used or currently using tobacco or nicotine products (give details).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Ever been or is currently a member of any alcohol or drug rehabilitation program.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Had a brother, sister, or parent who had and/or died from cancer, diabetes, stroke, heart or kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please describe any other health issues not mentioned above & list all medications:

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Insured's Name	Question Number	Date of Diagnosis	Diagnosis – Medication Prescribed