Pre-Underwriting Inquiry

Products and financial services provided by
The State Life Insurance Company
a ONEAMERICA® *company*
P.O. Box 406
Indianapolis, IN 46206
1-800-275-5101

ONEAMERICA®

Date _____

Please complete this form legibly and provide as much information as possible and email to *CSPUI@OneAmerica.com*. More details allow us to better assess the proposed risk. You may submit additional documentation with this form (a maximum of 5 pages) about the impairment questions.

Producer Information

Name | **Producer number**

Email (for response) | **Phone**

Client Information

Name | **Gender**

Date of birth | **Age** | **Height** | **Weight** | **Tobacco Y/N**

Product Options

Face amount or proposed premium (for single premium) _____

☐ Single Insured ☐ Joint Insureds* ☐ Name/other client _____

☐ Asset-Care: ☐ COB Rider ☐ Specific Duration _____ (Months) ☐ Lifetime

☐ Annuity Care I or Indexed Annuity Care: ☐ COB Rider ☐ Specific Duration _____ (months) ☐ Lifetime

☐ Annuity Care II: ☐ COB Rider Duration _____ (Months)

*When requesting a pre-underwriting inquiry on both clients for a joint policy, please complete and submit a separate form for each. Provide the name of the other client on each form.

I-27281 10/21/15

Medical Information to Assess

☐ Coronary (check if this section is not applicable)

Date of diagnosis/onset of chest pain _____ Number of involved vessels _____

Dates and details of treatment and/or surgery (e.g., angioplasty, bypass, etc.) _____

_____

Date of last testing (EKG, stress, stress echo, etc.) _____

Results _____

_____

Any symptoms since treatment/surgery _____

☐ Cancer (check if this section is not applicable)

Name/diagnosis and location _____

_____

Date of diagnosis _____ Stage/Grade/Metastasis _____

Dates/details of treatment and/or surgery _____

_____

Any recurrence _____ Date of last follow-up _____

☐ Diabetes (check if this section is not applicable)

Date of diagnosis _____ Type I or II _____

Treatment: ☐ Insulin ☐ Diet ☐ Medications

List insulin dosage and/or medications _____

_____

Date/result of last A1c _____

Has proposed insured been diagnosed with any of the following: ☐ Retinopathy ☐ Heart Disease
☐ Hypertension ☐ Neuropathy ☐ Kidney Disease ☐ Insulin Reaction ☐ Urine Protein/Microalbumin
☐ Cerebrovascular/Peripheral Vascular Disease?

_____

Other Medical Impairment

Name	Diagnosis	Date of onset	Date of last symptoms/treatment

Date/details of treatment/surgery _____

Testing/results _____

Current Medications

Name	Dosage	Reason for taking	Date first prescribed

Doctor's Visits

Date of last visit	Reason	Testing (all tests performed or scheduled)

Note: This is an underwriting opinion only and is based solely on the information provided. It is valid for 60 days. If proceeding with a formal application, please forward our email reply along with the rest of the paperwork. The offer is tentative and nonbinding, subject to favorable review of full age and amount requirements, medical and nonmedical records, ownership/beneficiary and any requested financial documentation.

Additional Questions or Comments

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_____

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