



Trinity Life Insurance Company

ADMINISTRATIVE OFFICE: PO BOX 5205 • FRANKFORT, KY 40602-5205
Phone: (866) 440-1357 • Fax: (502) 227-7205

FIELD UNDERWRITING QUESTIONNAIRE

Use when additional information is required.

Proposed Insured Information:

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Date of Birth:
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Height:	Weight:	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No	Face Amount:	Plan:
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1. What is the illness or impairment: _____
 Details: _____

2. Month / Year illness or impairment was diagnosed: _____

3. What treatment did you receive or are you receiving: _____

4. When did you last see your physician about your illness or impairment:
 0 to 6 months 6 to 12 months 12 to 24 months more than 24 months

5. What was your last cholesterol reading: _____, blood pressure reading _____ / _____

6. Any other illness or impairments: Yes No If "yes", please describe:

7. Please list medications taking currently: _____

8. Has either parent or any sibling died before age 65, other than by accident? Yes No If yes, list cause:

9. Please list the date(s) life insurance was applied for after your impairment was first diagnosed and the result:
 Company: _____ Date Applied: _____ Result: Standard Declined Postponed Rated
 Company: _____ Date Applied: _____ Result: Standard Declined Postponed Rated
 Company: _____ Date Applied: _____ Result: Standard Declined Postponed Rated

Notes:

Applicant's Signature: _____ Date: _____

Witness / Agent's Signature: _____ Date: _____

Completion of this form does not constitute a contract and is for company use only.