



Berkshire Advisor Resource, Inc.

Questionnaire: Back Health Prequalification

Please complete the following questions with as many details as possible. In this application supplement, "you" and "your" mean the Proposed Insured.

This application supplement is part of application(s) for insurance on: _____
Proposed Insured (please print)

1. In the last 10 years, have you had any symptoms, complaints, disorders, medical consultations or treatments concerning any of the following regions of the back? If you answer yes, insert dates of first and last symptoms.

Upper (neck/cervical region) Yes No Dates: _____

Middle (thoracic region) Yes No Dates: _____

Lower (lumbosacral region) Yes No _____

2. Describe your symptoms and reasons for medical consultations: _____

3. Name and address of physicians, chiropractors, or other therapists and month/year each was last seen: _____

4. Have you ever had surgery for any of these conditions: Yes No
If yes, give dates, reasons and name and address of hospital or facility: _____

5. Describe other type(s) of treatment received (manipulation, heat, physical therapy): _____

6. Has treatment included the use of prescription medications: Yes No List medications and start/stop dates: _____

7. Name prescribing physician (include address) if not shown in item 3 above: _____

8. Have you missed work more than 4 consecutive work days for any of the above conditions? Yes No
If yes, give dates and details: _____

Signature of Proposed Insured: _____ Date: _____