Pre-Underwriting Inquiry

Company response will address both Asset Care and Annuity Care

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®

Please complete the Client Information along with any pertinent medical history. Submit a separate form for each client. Provide as much information as possible and email to *cspui@oneamerica.com*.

Client Information *(REQUIRED)*			
Gender ☐ Male ☐ Female	Age	Height	Weight
Products Used *(select all that apply, current or within the last 12 months)* ☐ Tobacco ☐ Nicotine Products ☐ Marijuana	Frequency	Amount of Use	
Do you have any surgery, testing, or treatment pending/recommended? ☐ Yes ☐ No If YES, Provide Details			
Previously Declined by Another Company ☐ Yes ☐ No If YES, please attach a copy of the decline letter.	Currently/Previously Receive Social Security Disability Benefits ☐ Yes ☐ No		

Cardiac/Heart – Complete for All ***(Atrial Fibrillation, Coronary Artery Disease, or Valvular Heart Disease Require Additional Details)***	
Diagnosis	Date Diagnosed *(mm/yyyy)*
Dates and Results of Most Recent Cardiac Testing EKG, Catheterization, Echocardiogram, Stress Test	
Provide Details of Any Current Blockages or Recent Symptoms *(shortness of breath, chest pain, fatigue, lightheadedness, other)*	
Select All That Apply ☐ Stroke ☐ TIA ☐ Diabetes ☐ Peripheral Vascular Disease ☐ Cardiomyopathy ☐ Congestive Heart Failure ☐ Any Other Condition of the Heart	
Provide Dates and Details	

Atrial Fibrillation
Treatment *(select all that apply)* ☐ Medication ☐ Ablation ☐ Cardioversion ☐ Pacemaker ☐ Defibrillator
Provide Details *(include dates and medications)*

Coronary Artery Disease
Treatment *(select all that apply)* ☐ Medication ☐ Angioplasty ☐ Stenting ☐ Bypass Surgery ☐ Any Other Heart Surgery ☐ Any Left Main Involvement
History of Heart Attack ☐ Yes ☐ No
If YES, Provide Details *(include dates, medications, vessels involved and number of stents and/or vessels bypassed)*

Valvular Heart Disease
Which Valve(s) *(Aortic, Mitral, other)*
Treatment *(select all that apply)* ☐ Medication ☐ Surgery *(repair or valve replacement)*
Provide Dates and Details

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Cancer – Complete for All *(Breast, Prostate, Leukemia, and Lymphoma Require Additional Details)*

Diagnosis and Location | Date Diagnosed *(mm/yyyy)*

Stage, Grade, and Type | Size of Tumor

Lymph Node Involvement or Spread to Any Other Organs

Treatment *(select all that apply)*
☐ Surgery ☐ Chemo ☐ Radiation ☐ Other
| Date Last Treated *(mm/yyyy)*

Any Recurrence or Additional/Other Cancer
☐ Yes ☐ No

If YES, Provide Details as Outlined Above

Breast Cancer

Select Type
☐ Ductal ☐ Lobular ☐ Tubular ☐ Mucoid ☐ Papillary ☐ Medullary

Estrogen Receptor
☐ Positive ☐ Negative ☐ Unknown

Prostate Cancer

Gleason Score | PSA at Time of Diagnosis | Current PSA

Treatment *(select all that apply)*
☐ Surgery ☐ Chemo ☐ Radiation ☐ Active Surveillance ☐ Watchful Waiting ☐ Other
| Date Last Treated *(mm/yyyy)*

Leukemia

Select Type
☐ Acute Lymphoid *(lymphoblastic)* Leukemia (ALL) ☐ Acute Myeloid *(myelogenous leukemia)* (AML)
☐ Chronic Lymphocytic Leukemia (CLL) ☐ Hairy Cell Leukemia ☐ Chronic Myeloid Leukemia (CML)
| Age at Diagnosis

Lymphoma

Select Type
☐ Hodgkin's
☐ Non-Hodgkin's *(select subtype)*
☐ MALT Lymphomas ☐ Maltomas ☐ Extra Nodal Marginal Zone B-Cell
☐ Follicular ☐ Transformed Follicular ☐ Nodal Marginal Zone B-Cell
☐ Diffuse Large B-Cell ☐ Burkitt ☐ Mantle Cell ☐ Peripheral T-Cell ☐ Other High-Grade Lymphoma
☐ Cutaneous Lymphoma ☐ Mycosis Fungoides ☐ Sèzary Syndrome
☐ Adult T-Cell Lymphoma/Leukemia

Diabetes

Date Diagnosed *(mm/yyyy)* | Type of Diabetes ☐ Type I ☐ Type II | Date Last Tested A1C *(mm/yyyy)* | A1C Result

Names and Dosage of Medications

Select All That Apply
☐ Retinopathy
☐ Background ☐ Proliferative
☐ Heart Disease ☐ Neuropathy ☐ Kidney Disease ☐ Urine Protein/Microalbumin
☐ Cerebrovascular ☐ Peripheral Vascular Disease ☐ Skin Ulcers ☐ Amputations

Provide Dates and Details

Mental/Nervous

Select All That Apply
☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADD/ADHD ☐ PTSD

Date Diagnosed *(mm/yyyy)*

Medication Dosage and Any Other Treatment

Any Hospitalizations or ER Visits
☐ Yes ☐ No

Provide Details *(including dates and length of stay)*

Alcohol and/or Drug Abuse

Substance(s)

Date Last Used *(mm/yyyy)*

Treatment *(select all that apply)*
☐ Medication ☐ Hospitalization ☐ Treatment Programs ☐ Support Group

Provide Date Last Treated and Details

Any Relapse
☐ Yes ☐ No

Complications
☐ Yes ☐ No

If YES, Provide Dates and Details

Musculoskeletal

Diagnosis

Date Diagnosed *(mm/yyyy)*

Treatment *(select all that apply)*
☐ Medications
☐ Injection

Injection Type *(if applicable)*

Injection Frequency*(if applicable)*

Date of Last Injection *(mm/yyyy) (if applicable)*

Physical Therapy
☐ Yes ☐ No

Use of Any Assistive Devices
☐ Yes ☐ No

Any Functional Limitations
☐ Yes ☐ No

Surgery Recommended or Planned
☐ Yes ☐ No

If YES to Any of the Above, Provide Complete Details

Osteoporosis

Date of Last Bone Density *(mm/yyyy)*

Provide Actual T-Scores

Any Falls/Broken Bones/Fractures
☐ Yes ☐ No If YES, Provide Date and Location

Treatment

Respiratory/Asthma/COPD/Sleep Apnea

Diagnosis

Date Diagnosed *(mm/yyyy)*

Treatment

Any Prior Tobacco Use
☐ Yes ☐ No If YES, Date Last Used *(mm/yyyy)*

Hospitalizations, ER Visits or Any Limitations Due to Shortness of Breath
☐ Yes ☐ No

Any Use of Supplemental Oxygen
☐ Yes ☐ No

If YES, Provide Details

Stroke/TIA

Select All That Apply	Date(s) Diagnosed *(mm/yyyy)*
☐ Stroke ☐ Single ☐ Multiple ☐ TIA ☐ Single ☐ Multiple	

Treatment

List Any Residuals

Other Medical Impairments Not Listed Above and All Current Medications

Impairment	**Treatment, Medication *(include dosage)*, Surgery**	**Date(s) *(mm/yyyy)***

Additional Comments