Gastric Bypass Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

State of Residence: _____

___Term 10 15 20 30 __UL

1. When did the proposed insured have gastric bypass surgery? _____

2. What was the proposed insured's weight prior to having surgery? _____

3. How long as the proposed insured maintained their current weight? _____

4. Did, the proposed insured, received treatment for medical conditions prior to the surgery that no longer require treatment? (E.G., diabetes, hypertension, heart disease) ___Yes ___No
(If yes, please provide details, including condition, treatment received, and when treatment ended):
_____
_____
_____
_____

5. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and condition they are taking the medication for):
_____
_____
_____
_____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787