TOBACCO QUESTIONNAIRE

1. Name of Proposed Insured	2. Date of Birth

3. Do you use tobacco in any form? ☐ Yes ☐ No	6. If (5) is answered "Yes,"
4. If (3) is answered "Yes," a) What do you use?________ b) How often or many per day?________	a) When did you stop?________ b) Did you stop on advice of a physician? ☐ Yes ☐ No If "Yes," please give reason(s) and name and address of physician.
5. If (3) is answered "No," a) Have you used tobacco within the past 5 years? ☐ Yes ☐ No b) What did you use?________	________ ________ ________

I represent that the answers to the above questions are true to the best of my knowledge and belief.

Signed at________________ Date________

________________ ________________
Witness Signature of Proposed Insured