

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*



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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight
Products Used <i>(select all that apply, current or within the last 12 months)</i> <input type="checkbox"/> Tobacco <input type="checkbox"/> Nicotine Products <input type="checkbox"/> Marijuana		Frequency	Amount of Use
Do you have any surgery, testing, or treatment pending/recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Provide Details			
Previously Declined by Another Company <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please attach a copy of the decline letter.		Currently/Previously Receive Social Security Disability Benefits <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(shortness of breath, chest pain, fatigue, lightheadedness, other)</i>			
Select All That Apply <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Any Other Condition of the Heart			
Provide Dates and Details			
Atrial Fibrillation			
Treatment <i>(select all that apply)</i> <input type="checkbox"/> Medication <input type="checkbox"/> Ablation <input type="checkbox"/> Cardioversion <input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator			
Provide Details <i>(include dates and medications)</i>			
Coronary Artery Disease			
Treatment <i>(select all that apply)</i> <input type="checkbox"/> Medication <input type="checkbox"/> Angioplasty <input type="checkbox"/> Stenting <input type="checkbox"/> Bypass Surgery <input type="checkbox"/> Any Other Heart Surgery <input type="checkbox"/> Any Left Main Involvement			
History of Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, Provide Details <i>(include dates, medications, vessels involved and number of stents and/or vessels bypassed)</i>			
Valvular Heart Disease			
Which Valve(s) <i>(Aortic, Mitral, other)</i>			
Treatment <i>(select all that apply)</i> <input type="checkbox"/> Medication <input type="checkbox"/> Surgery <i>(repair or valve replacement)</i>			
Provide Dates and Details			

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) <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Other	Date Last Treated (mm/yyyy)
Any Recurrence or Additional/Other Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, Provide Details as Outlined Above	

Breast Cancer

Select Type <input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Tubular <input type="checkbox"/> Mucoïd <input type="checkbox"/> Papillary <input type="checkbox"/> Medullary	Estrogen Receptor <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
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Prostate Cancer

Gleason Score	PSA at Time of Diagnosis	Current PSA
Treatment (select all that apply) <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Active Surveillance <input type="checkbox"/> Watchful Waiting <input type="checkbox"/> Other		Date Last Treated (mm/yyyy)

Leukemia

Select Type <input type="checkbox"/> Acute Lymphoid (lymphoblastic) Leukemia (ALL) <input type="checkbox"/> Acute Myeloid (myelogenous leukemia) (AML) <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Chronic Myeloid Leukemia (CML)	Age at Diagnosis
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Lymphoma

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

Diabetes

Date Diagnosed (mm/yyyy)	Type of Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	Date Last Tested A1C (mm/yyyy)	A1C Result
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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 <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> PTSD	Date Diagnosed (mm/yyyy)
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Medication Dosage and Any Other Treatment

Any Hospitalizations or ER Visits <input type="checkbox"/> Yes <input type="checkbox"/> No	Provide Details (including dates and length of stay)
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Alcohol and/or Drug Abuse

Substance(s)	Date Last Used (mm/yyyy)
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Treatment (select all that apply)			
<input type="checkbox"/> Medication	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Treatment Programs	<input type="checkbox"/> Support Group

Provide Date Last Treated and Details

Any Relapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Complications <input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES, Provide Dates and Details

Musculoskeletal

Diagnosis	Date Diagnosed (mm/yyyy)
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Treatment (select all that apply) <input type="checkbox"/> Medications <input type="checkbox"/> Injection	Injection Type (if applicable)	Injection Frequency (if applicable)	Date of Last Injection (mm/yyyy) (if applicable)
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Physical Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Use of Any Assistive Devices <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Functional Limitations <input type="checkbox"/> Yes <input type="checkbox"/> No
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Surgery Recommended or Planned <input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES to Any of the Above, Provide Complete Details

Osteoporosis

Date of Last Bone Density (mm/yyyy)	Provide Actual T-Scores
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Any Falls/Broken Bones/Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Provide Date and Location
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Treatment

Respiratory/Asthma/COPD/Sleep Apnea

Diagnosis	Date Diagnosed (mm/yyyy)
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Treatment

Any Prior Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Date Last Used (mm/yyyy)
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Hospitalizations, ER Visits or Any Limitations Due to Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Use of Supplemental Oxygen <input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES, Provide Details

Stroke/TIA

Select All That Apply <input type="checkbox"/> Stroke <input type="checkbox"/> Single <input type="checkbox"/> Multiple <input type="checkbox"/> TIA <input type="checkbox"/> Single <input type="checkbox"/> Multiple	Date(s) Diagnosed (<i>mm/yyyy</i>)
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Treatment

List Any Residuals

Other Medical Impairments Not Listed Above and All Current Medications

Impairment	Treatment, Medication (<i>include dosage</i>), Surgery	Date(s) (<i>mm/yyyy</i>)

Additional Comments

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