



# financial life

A Fraternal Benefit Society

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## DRUG USE QUESTIONNAIRE TO BE COMPLETED BY THE PROPOSED INSURED PROVIDE DETAILS FOR ANY POSITIVE RESPONSE

Name of Proposed Insured: \_\_\_\_\_ DOB: \_\_\_\_\_  
MM/DD/YYYY

1) Are you currently using or have you in the last 5 years used or abused illegal or controlled substances? Check all drugs used or write in name of drugs if not listed:

- |  |                                  |                                       |                                   |                                    |                                       |
|--|----------------------------------|---------------------------------------|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> opium derivatives | <input type="checkbox"/> heroine | <input type="checkbox"/> morphine     | <input type="checkbox"/> percodan | <input type="checkbox"/> demerol   | <input type="checkbox"/> methadone    |
| <input type="checkbox"/> marijuana         | <input type="checkbox"/> hashish | <input type="checkbox"/> amphetamines | <input type="checkbox"/> cocaine  | <input type="checkbox"/> crack     | <input type="checkbox"/> barbiturates |
| <input type="checkbox"/> phenobarbital     | <input type="checkbox"/> LSD     | <input type="checkbox"/> hydrocodone  | <input type="checkbox"/> codeine  | <input type="checkbox"/> oxycodone | <input type="checkbox"/> vicodin      |
| <input type="checkbox"/> hallucinogens     | <input type="checkbox"/> PCP     | <input type="checkbox"/> crystal meth | <input type="checkbox"/> speed    | <input type="checkbox"/> librium   | <input type="checkbox"/> alcohol      |

How much? \_\_\_\_\_ How often? \_\_\_\_\_ Date of your first use? \_\_\_\_\_ Date of your last use? \_\_\_\_\_

2) In the last 5 years, have you received medical treatment by a physician, or counseling by a counselor or clergy because of drug or alcohol use? If yes, provide dates, names and addresses of all treatment facilities.

\_\_\_\_\_

3) Have you within the past 5 years plead guilty to or been convicted of a driving violation due to drug or alcohol or failed or refused to take a breathalyzer test?

\_\_\_\_\_

4) In the past 5 years, have you experienced job difficulties, missed work, had family problems or legal problems due to drug or alcohol use?

\_\_\_\_\_

5) In the past 5 years, have you been in an altercation or arrested or charged with an alcohol related offense?

\_\_\_\_\_

6) In the last 5 years, have you received medical treatment caused by drug or alcohol use?

\_\_\_\_\_

7) Have you been a member of AA, NA or other support group for drug or alcohol use within the last 5 years? If yes, provide name of group, date first attended, date last attended, how often do you attend?

\_\_\_\_\_

8) Current height and weight? \_\_\_\_\_ Weight one year ago? \_\_\_\_\_

I understand that this declaration will be relied upon by 1891 Financial Life in determining my insurability. A false statement on this application will not prevent the right to receive the benefit unless the false statement was made with the actual intent to deceive and unless it materially affected the acceptance of the risk assumed by the insurer. I declare that the above answers are true and complete to the best of my knowledge and belief.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

*If age 16 or over, or Parent or Guardian if under age 16 or the age of majority required by the state where the policy is issued for delivery*