

NAME			
FIRST NAME			
DATE OF BIRTH			APPLICATION OR POLICY NUMBER
D	M	Y	

TOBACCO QUESTIONNAIRE

1. Do you use:

	YES	NO	QUANTITY PER DAY	SINCE WHEN
a) Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>		
b) Cigars, Cigarillos	<input type="checkbox"/>	<input type="checkbox"/>		
c) Pipe	<input type="checkbox"/>	<input type="checkbox"/>		
d) Chewing Tobacco	<input type="checkbox"/>	<input type="checkbox"/>		
e) Other Substances (Ex: marijuana...)	<input type="checkbox"/>	<input type="checkbox"/>		
f) Electronic Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>		

2. If you have used any of the above in the past and have given up the habit:

a) When did you last used? _____

b) Why did you quit?

- On your doctor's advice? _____

- Other? (Provide the complete details) _____

c) Please provide the complete details of the type of substances used and the quantity consumed per day:

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X _____
SIGNATURE OF THE PROPOSED INSURED

X _____
SIGNATURE OF THE POLICY OWNER

X _____
WITNESS

DATE