

Substance Usage Supplement Forming Part of The Application for Insurance

Name _____ Proposed Insured
 Additional/Joint Insured

1. Do you currently use or have you ever used:
- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| a. Alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Marijuana? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Heroin, morphine, or other narcotic drug? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Barbiturates, sedatives, or tranquilizers? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Cocaine, crack? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. LSD, or any other hallucinogens? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Amphetamines? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

2. Give details of any "yes" answers to 1 a-h:

Type	Amount Used	Frequency (daily, weekly, monthly, yearly)	Dates Used	
			From	To

3. If your substance usage habits have lessened, when and why did you change?

- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 4. Have you ever consulted a doctor, psychiatrist, psychologist, or received counseling or treatment for substance usage? | <input type="checkbox"/> | <input type="checkbox"/> |

If "yes", provide details of all counseling or treatments, including dates, length of treatment, name and address of physician, counselor, or facility:

- | | | |
|---|--------------------------|--------------------------|
| 5. Do you currently use, or have you used alcohol or drugs since your last treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If "yes", provide details including date, city and state of each occurrence

- | | | |
|---|--------------------------|--------------------------|
| 6. Have you ever been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar organization? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If "yes",

a. Name of organization _____	c. Date last attended _____
b. Date first attended _____	e. How often do you attend meetings? _____
d. Are you currently active? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- | | | |
|--|--------------------------|--------------------------|
| 7. Have you ever been charged with driving while intoxicated or driving under the influence? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If "yes", provide details including date, city and state of each occurrence _____

8. Please add any additional information you feel is relevant to our evaluation:

I represent that the statements and answers in this Supplement are true and complete.

Signature of Proposed Insured/Additional Joint Insured

Date

Signature of Licensed Financial Professional/Insurance Broker