

Drug/Alcohol Usage Questionnaire



PLEASE PRINT

1 Name of Proposed Insured _____ Date of Birth _____

2 Are you now using or have you in the last 10 years used any of the following:

Drug(s): <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate which of the following you use(d):	
<input type="checkbox"/> Opium derivatives: Heroin, Morphine, Demerol, Codeine, Percodan, Dilaudid	<input type="checkbox"/> Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital
<input type="checkbox"/> Marijuana: Hashish, Cannabis	<input type="checkbox"/> Amphetamines: Methamphetamine (Meth), Benzedrine, Dexedrine, Adderall, Ritalin
<input type="checkbox"/> Cocaine, Crack	<input type="checkbox"/> Hallucinogens: LSD, Mescaline, Peyote, Psilocybin, PCP
<input type="checkbox"/> Sedatives and Tranquilizers: Xanax, Librium, Valium, Quaalude, Dalmane, Placidyl	<input type="checkbox"/> Antabuse, Methadone, Naloxone (Narcan)
Date last used: _____	Amount Used: _____
Frequency of use: _____	How long did/have you used them? _____
How taken? (Oral, Injection, Inhaled, Smoked, Etc.) _____	
Were any of the above drugs prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "Yes," which? _____	

Alcoholic beverage(s): <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," indicate which of the following you use(d):		
<input type="checkbox"/> Beer	<input type="checkbox"/> Wine	<input type="checkbox"/> Liquor
Date last used: _____	Amount Used: _____	
Frequency of use: _____	How long did/have you used them? _____	
Did you ever drink substantially more than at present? <input type="checkbox"/> Yes <input type="checkbox"/> No. If "Yes," during what time period?		
Dates: From _____ To _____	By how much more? _____	
Why did you change your drinking habits? _____		

3 Have you ever received medical treatment or been advised to seek treatment because of:

(a) **Drugs:** Yes No

(b) **Alcohol:** Yes No

If "Yes," names(s) of doctor/facility, address and dates of treatment: _____

4 Have you ever joined or attended a support group (such as AA or NA) because of:

(a) **Drugs:** Yes No

(b) **Alcohol:** Yes No

If "Yes," are you still an active member of a support group? Yes No

5 Except those prescribed by a physician, are you now using or have you used during the last 10 years any other drugs not listed in number 2 above? Yes No

If "Yes," please provide details: _____

6 Have you ever been arrested, charged or convicted (including DUI) in connection with the use or sale of:

(a) **Drugs:** Yes No

(b) **Alcohol:** Yes No

If "Yes," list dates: _____

7 Please provide any additional explanation or details _____

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

Witnessed Signature of Proposed Insured _____ Date _____

Signature of Witness _____ Date _____