

NATIONAL BROKERAGE AGENCY, INC.

DRUG USAGE QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
Address: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. Indicate any of the following drugs you are currently using or have used in the past:
 Opium derivativ Heroin Morphine Demerol Methadon
 Barbituates Phenobarbita Amytal Seconal Nembutal
 Marijuana Hashish Cannabis
 Amphetamines Benzedrine Dexedrine Methedrine
 Cocaine Crack Any derivativ
 Hallucinogens LSD DMT Mescaline Peyote Psilocybin
 IV drug use
 Other: _____
2. Please note details on the above mentioned:
Type: _____ Quantity: _____
Frequency: _____ Date last used: _____
Type: _____ Quantity: _____
Frequency: _____ Date last used: _____
Type: _____ Quantity: _____
Frequency: _____ Date last used: _____
Type: _____ Quantity: _____
Frequency: _____ Date last used: _____
3. Do you consume any alcohol? No Yes, Details: _____
4. Have you ever suffered from any liver disorder (i.e., enlarged liver, elevated Liver Function Tests) due to drug use? No Yes, Details: _____
5. Have you ever been confined to bed, or lost your job due to your connection with drugs?
 No Yes, Details: _____
6. Have you ever been arrested or charged in connection with the drugs?
 No Yes, Details: _____
7. Have you had any moving traffic violations in the last 5 years? No Yes, Details: _____
 Violations Number: _____ Type: _____ Dates: _____
 Accidents Number: _____ Were you at fault? Yes No
 License suspensions or revocations : Dates: _____
Reasons _____
8. Are you on any medication(s)? No Yes, Name(s) and dosage(s): _____
9. Date you last consulted your physician: _____
10. Have you ever received treatment or counseling, consulted or been advised by a doctor, medical facility, or support group (Alcoholics Anonymous, Narcotics Anonymous, etc.) because of your drug use?
 No Yes, Name and address(es) of any doctor(s), hospital(s), and/or treatment center(s): _____

This information is confidential return to NBA member only.

Date: _____ Proposed Insured's Signature: _____