

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor **Type of Coverage:** Term UL Survivor

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death.

| PROPOSED INSURED'S EXISTING INSURANCE | | | |
|---------------------------------------|-------------|-------------|---------------------------|
| Full Name of Company | Face Amount | Year Issued | Is Policy to be Replaced? |
| | | | |
| | | | |

1. At what age was it first diagnosed? _____
2. Is client disabled? No Yes; please give details
- _____
- _____

3. Is client on any medications? (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
| | | |
| | | |
| | | |
| | | |
| | | |

4. Does client have any other major health issues? (additional questionnaires may be required) No Yes; please give details
- _____
- _____