



GENERAL USE QUESTIONNAIRE

(IF THERE IS NOT A SPECIFIC IMPAIRMENT QUESTIONNAIRE, THEN PLEASE COMPLETE THIS FORM)

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. List impairment: (Give as much detail as possible, include when the condition was diagnosed, how it was contracted, and current prognosis)

2. Has there been any treatment? No Yes; (Please provide start and end dates, name of treatment.)

3. Is client on any medications now? (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

