

**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. Date first diagnosed: \_\_\_\_\_

2. Please check if any of these conditions are present (complete questionnaire for each condition checked):

- Diabetes
- Polycystic kidney disease
- Glomerulonephritis
- Nephrosclerosis
- Systemic lupus erythematosus
- Other: \_\_\_\_\_

3. Give most recent results of kidney function tests:

- BUN \_\_\_\_\_
- Serum creatinine \_\_\_\_\_
- Urinalysis \_\_\_\_\_

4. Have any of the following occurred (check all that apply):

- Frequent infection
- High blood pressure
- Cardiovascular disease (complete questionnaire for this condition)

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

(Accurate) Name of Medication	Dosage	Reason

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

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