

**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 of diagnosis? \_\_\_\_\_  
 Benign vs.  Malignant  
 Single vs.  Multiple

2. What evaluation was done? Please give date and results.  
 MRI, CT Date: \_\_\_\_\_  
 Urine Test Date: \_\_\_\_\_  
 Blood Test Date: \_\_\_\_\_

3. Has your client had surgery to remove a pheochromocytoma?  No  Yes; please give dates and details

\_\_\_\_\_

\_\_\_\_\_

4. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

5. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details

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