

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 Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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 diagnoses: _____ Type of breast cancer: _____

2. How was the cancer treated? (Check all that apply)

- Excisional biopsy only
- Lumpectomy or wide excision
- Mastectomy
- Radiation therapy
- Chemotherapy
- Hormonal therapy: _____

Additional/Other: _____

Receptor (ER, PR) status: _____

HER2 status: _____

3. List date treatment was completed: _____

4. Is client on any medications? No Yes; please give details _____

5. What stage was the cancer? TNM Staging: _____

- Stage 0 (in-situ)
- Stage IA
- Stage IB
- Stage IIA
- Stage IIB
- Stage IIIA
- Stage IIIB
- Stage IIIC
- Stage IV

6. Were lymph nodes involved? No Yes; If yes, how many? _____

7. Has there been any evidence of recurrence? No Yes; please give details _____

8. Date and results of last mammogram: _____

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