

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: _____

2. What was the pretreatment PSA? _____

3. How was the cancer treated? (check all that apply)

Observation only TURP (transurethral prostatectomy) Radical prostatectomy

Radiation therapy (seed implant or external beam radiation)

4. What is date and result of the most current PSA test? _____

5. What was the Gleason score? _____ (Please specify break down above Gleason 6; e.g., for Gleason 7, specify if 4+3 or 3+4).

6. What stage was the cancer?

Stage 0 (in-situ) Stage I Stage II Stage III Stage IV **TNM Staging:** _____

7. Is there a family history of cancer? No Yes

8. What medications is client taking? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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