

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(s) of diagnoses: _____

2. What was the type of cancer was diagnosed? Basal cell carcinoma Squamous cell carcinoma Malignant melanoma

3. Where was the skin cancer located? _____ Treatment?: _____

4. Has the cancer metastasized (spread) beyond the skin?

No Yes; please give details _____

5. Has there been any evidence of recurrence?

No Yes; please give details _____

6. For malignant melanoma only, what stage was the cancer?

TNM Staging: _____ (* Required for Melanoma prescreen)

Clark I/in situ Clark II/Breslow < 0.75mm Clark III/Breslow .75–1.5mm Clark IV/Breslow 1.51–4.0mm

Clark V/Breslow > 4.0mm

7. Any history of dysplastic nevi? No Yes; Total number: _____

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

(Accurate) Name of Medication	Dosage	Reason

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