

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 diagnosis? _____ Cause, if known (Benign Tumor, Adrenal Hyperplasia, Steroid Medication use, Other (please provide details)): _____
2. What evaluation was done? Please give date and results.

MRI, CT Date: _____ / _____ / _____ Urine Test Date: _____ / _____ / _____

Blood Test Date: _____ / _____ / _____

3. Has your client ever been hospitalized for Cushing syndrome? No Yes; please give details
- _____
- _____

4. Has your client been prescribed steroids for any other illness? No Yes; please give details
- _____
- _____

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

(Accurate) Name of Medication	Dosage	Reason

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