

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. List the diagnosis: _____ Date of diagnosis: _____

2. Please indicate: Number of episodes: _____ Date of last episode: _____

3. Has client been hospitalized for psychiatric treatment? No Yes; please give dates and lengths of stay.

4. Does client have a history of any of the following associated conditions? Please check all that apply. (Additional questionnaires may be required)

Personality disorder

Psychotic disorder

Suicidal thoughts/attempt (current or past)

Substance use disorder (alcohol or drugs; current or past) (complete questionnaire)

Other psychiatric disorder _____

5. Is the client currently working? No Yes; please list occupation

6. Has any time been lost from work as a result of condition? No Yes; please give details

7. Has the client had any medication changes in the past 12 months? _____

8. 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