

**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 first diagnosed: \_\_\_\_\_

2. Please check if any of these conditions are present (complete questionnaire for each condition checked):

- Diabetes
- Polycystic kidney disease
- Glomerulonephritis
- Nephrosclerosis
- Systemic lupus erythematosus
- Other: \_\_\_\_\_

3. Give most recent results of kidney function tests:

- BUN \_\_\_\_\_
- Serum creatinine \_\_\_\_\_
- Urinalysis \_\_\_\_\_

Urine albumin \_\_\_\_\_  
 Urine creatinine \_\_\_\_\_  
 Urine protein \_\_\_\_\_

4. Have any of the following occurred (check all that apply):

- Frequent infection
- High blood pressure
- Cardiovascular disease (complete questionnaire for this condition)

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

(Accurate) Name of Medication	Dosage	Reason

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

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