



MENTAL HEALTH

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

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. Describe client's condition. Give the diagnosis.

2. Date of first symptoms? _____

3. When did client last see doctor for this condition? _____

4. Has client been hospitalized No Yes; (list all)

Date: _____

Date: _____

5. Is client currently employed? No Yes

6. Has condition interfered with work? No Yes, If so, how long? _____

7. Is client disabled? No Yes; please give details

8. List all medications client is taking. (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
| | | |
| | | |
| | | |

9. When was the last medication adjustment made?

Details _____

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