

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?

Current build: Height: _____ Weight: _____

Change in weight over the last 12 months:

Yes: Increase _____ lbs. Decrease _____ lbs. Method of weight loss (e.g., diet/exercise, medications, etc.): _____

No

1. Has client ever had any weight reduction surgery? No Yes; please give details

2. Please check if your client has had any of the following: (If any of the listed is checked off, request the specific questionnaire)

Coronary artery disease

Diabetes

High blood pressure

Elevated cholesterol or triglycerides (lipid Levels)

3. Is client on any medications? (accurate name, dosage, and reason): _____

4. Has a stress electrocardiogram (treadmill test) been completed within the past year?

Yes—normal Date: _____

Yes—abnormal Date: _____

No

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