CEREBRAL PALSY

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. At what age was it first diagnosed? _____

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

(Accurate) Name of Medication	Dosage	Reason

3. Does the client require mobility aids (e.g., cane, walker, wheelchair, etc.)? No☐ Yes☐; please provide details:

_____

4. Does the client require assistance with activities of daily living (e.g., bathing, dressing, etc.)? ☐ No ☐ Yes

5. Does the client experience seizures? ☐ No ☐ Yes; Type: _____ Frequency: _____ Most recent: _____

6. Has there ever been a diagnosis related to intellectual difficulties? ☐ No ☐ Yes; please provide details:

_____

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

_____

_____

