

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. Please list date of diagnosis: _____

2. Please indicate the type of treatment:

- Phlebotomy Splenectomy
- Hydroxyurea Interferon
- Radioactive Phosphorus Chemotherapy

3. What is current therapy? _____

4. Please provide the date and results of the most recent CBC:

- Hematocrit (Hct) _____
- Hemoglobin (Hb) _____
- Platelet Count _____
- White Blood Cell (WBC) _____

5. Is your client on any medications?

- yes, please give details _____
- no

6. Has your client smoked cigarettes in the last 12 months?

- yes, please give details _____
- no

7. Does your client have any other major health problems (ex: cancer, etc.)?

- yes, please give details _____
- no