CLIENT NAME: _____ **Date:** _

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine p

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?

If your client has headaches, please answer the following:

1. Date when first diagnosed.

_____

2. What type of headache was diagnosed?

☐ Migraine

☐ Cluster

☐ Tension

☐ Other: _____

3. Was your client incapacitated from work due to the headache?

☐ Yes. If yes, when and for how long? _____

☐ No

4. Please describe frequency and duration **of attacks.**

_____

_____

5. Please give date of most recent attack.

_____

6. Is your client on any medications?

☐ Yes. (Please give details.) _____

☐ No

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

☐ Yes ☐ No

8. Does your client have any other major health problems (e.g., heart disease, etc.)?

☐ Yes. (Please give details.) _____

☐ No