

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. List date of first diagnosis: _____

Type:

2. Indicate number of episodes: _____

___ Progressive

___ Relapsing-Remitting

3. Date of last episode: _____

4. Please note current neurological status and/or symptoms.

☐ No current symptoms or functional impairment

☐ Minimal residual symptoms (please specify) _____

☐ Moderate residual symptoms (please specify) _____

☐ Severe residual (please specify) _____

5. What are client's current symptoms?

6. What therapy is client on?

7. Does client have any problems with extremities, kidneys, or bladder? ☐ No ☐ Yes; please give details

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

(Accurate) Name of Medication	Dosage	Reason

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