ALCOHOL USAGE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Does client presently consume alcoholic beverages? ☐ No ☐ Yes, If yes, please list

☐ Beer: Quantity _____ oz. per ☐ day ☐ week ☐ month (select one)

☐ Wine: Quantity _____ oz. per ☐ day ☐ week ☐ month (select one)

☐ Liquor: Quantity _____ oz. per ☐ day ☐ week ☐ month (select one)

2. What was the date of initial treatment or diagnosis? _____ / _____ / _____

3. Were there any relapses from sobriety/abstinence? ☐ No ☐ Yes; please provide details and dates

_____

_____

_____

4. Were there any legal problems (such as DUI) or other? ☐ No ☐ Yes; please provide details and dates

_____

_____

_____

_5. Have there been physical complications or additional psychiatric problems? ☐ No ☐ Yes; please provide details and dates, including use of other substances such as marijuana or cocaine

_____

_____

_____

6. Does client currently participate in a group such as Alcoholics Anonymous? ☐ No ☐ Yes

(Accurate) Name of Medication	Dosage	Reason

7. Please list current medications (accurate name, dosage, and reason):

8. What is client's: Martial status: _____

Occupation: _____ Length of employment: _____

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

_____

_____

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ANGIOPLASTY

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 the date(s) of the angioplasty (PTCA): _____

2. How many vessels required the procedure? _____

3. Why was an angioplasty done? (give specific details)

_____

_____

_____

4. Does client's family have any history of heart disease? ☐ No ☐ Yes

5. Has client had either of the following? ☐ Heart attack _____ (date), ☐ Bypass surgery _____ (date)

6. Has a follow-up stress (exercise) ECG been completed since procedure?

☐ Yes. normal _____ (date) ☐ Yes. abnormal _____ (date) ☐ No

7. Has client had any chest discomfort since the procedure? ☐ No ☐ Yes; please give details

_____

_____

_____

8. Has client had any of the following?

☐ abnormal lipid levels ☐ diabetes ☐ overweight ☐ elevated homocysteine ☐ high blood pressure ☐ peripheral vascular disease

☐ irregular heart beats ☐ cerebrovascular ☐ carotid disease

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

_____

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ANXIETY DISORDERS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. ☐ Generalized anxiety disorder ☐ Panic disorder

   ☐ Obsessive compulsive disorder ☐ Post-traumatic stress syndrome

   ☐ Agoraphobia ☐ Other anxiety disorder _____

3. Indicate the number of episodes and date of last episode/recovery: _____

4. Is client on any medications: ☐ No ☐ Yes; please provide name and dosage _____

5. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness? ☐ No ☐ Yes, please give dates and lengths of stay. _____

6. Does client have a history of any of the following associated conditions? (check all that apply)

   ☐ Depression ☐ Suicidal thought/attempt

   ☐ Substance abuse (alcohol or drugs) ☐ Other psychiatric disorder _____

7. Is the client currently working? ☐ No ☐ Yes (occupation)_____

8. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give full details

_____

_____

_____

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

_____

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ARTHRITIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What type of arthritis is it? (Example: rheumatoid, osteo, gouty, etc.)

_____

_____

2. When was it initially diagnosed? _____

3. Are the joints involved? ☐ No ☐ Yes

4. What is the type of treatment, and does it include cortisone?

_____

_____

_____

5. Please list current medications, (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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ATRIAL FIBRILLATION

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. Is the atrial fibrillation/flutter: ☐ Chronic (permanent) ☐ Proxysmal (intermittent)

3. Are there any symptoms with the irregular heart beat?

☐ Black-out ☐ Dizziness (light-headedness)/faint feeling

☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:

☐ ECG _____

☐ Stress test _____

☐ Echocardiogram _____

☐ Holter monitor _____

5. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:

☐ Coronary heart disease ☐ Alcohol

☐ Thyroid disease ☐ Cardiomyopathy

☐ Mitral valve disease ☐ Unknown

☐ Other, give details _____

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

_____

_____

_____

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AVOCATIONS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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?

MOUNTAIN CLIMBING

Kind of climbing: ☐ Mountain ☐ Rock ☐ Trail ☐ Ice Years of experience: _____

Number of climbs in the last 24 months: _____ Number of climbs in the next 12 months: _____

Climbs Outside the Continental U.S.	Date	Climbs Inside the Continental U.S.	Date

UNDERWATER DIVING

How long have you been diving? _____ yrs. _____ mth(s). What certification(s) do you hold? _____

What kind of equipment do you use? _____ Do you ☐ Cave ☐ Wreck ☐ Salvage dive? ☐ No

Dive Depths	During the Past 12 Months		Contemplated in the Next 12 Months	
Under 75 ft.				
76 ft. to 150 ft.				
150 ft. or deeper				

SKY DIVING

What kind of license do you hold? _____ How many jumps have you logged?

What events do you participate in? Please explain: _____

Do you jump professionally or use experimental equipment? Please explain: _____

Number of jumps in the last 24 months: _____ Number of jumps in the next 12 months: _____

HANG GLIDING, ULTRA LIGHT FLYING, AND HOT AIR BALLOONS

Type of craft flown _____ _____ Type of terrain _____ _____

Number of flights in the next 12 months: _____ Maximum flight altitude: _____

Do you participate in competitive or stunt events? ☐ Yes ☐ No Are you a licensed pilot? ☐ Yes ☐ No

What certification(s) do you hold? _____

With the avocation above, do you belong to any organized clubs? ☐ No ☐ Yes, please list _____

Additional notes: _____

_____

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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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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?

☐ Yes: Increase _____ lbs. Decrease _____ lbs.

☐ 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

_____

_____

_____

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BUNDLE BRANCH BLOCK

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 check type of BBB present:

☐ CLBBB ☐ CRBBB ☐ LAHB or LPHB ☐ IRBBB ☐ Bifascicular block

2. How long has this abnormality been present? _____ (years)

3. Has there been any recent change in the ECG?

☐ No ☐ Yes; please give details _____

_____

_____

4. Please check if your client has had any of the following: (check all that apply)

☐ Chest pain or coronary artery disease
☐ Cardiomyopathy
☐ High blood pressure
☐ Congenital heart disease
☐ Valvular heart disease

5. Have any cardiac studies been completed?

a. Exercise treadmill or thallium: ☐ No ☐ Yes—normal ☐ Yes—abnormal
b. Resting or exercise echocardiogram: ☐ No ☐ Yes—normal ☐ Yes—abnormal
c. Other: ☐ No ☐ Yes—normal ☐ Yes—abnormal

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

_____

_____

7. Does your client have any other major health problems? (ex: cancer, etc.) ☐ No ☐ Yes; please give details

_____

_____

_____

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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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What type of cancer was diagnosed? _____

2. List date of first diagnosis: _____

3. Is there a family history of cancer?
☐ No ☐ Yes; please give details _____
_____

4. How was the cancer treated?
☐ Surgery ☐ Chemotherapy ☐ Radiation therapy ☐ Hormonal therapy ☐ Immunotherapy
☐ Other (give full details)

5. List date treatment was completed: _____

6. What was the stage and grade of the cancer? _____

7. Has there been any evidence of reoccurrence? ☐ No ☐ Yes; please give details _____
_____

8. What did the pathology report reveal? _____
_____

9. What medications is client taking? (accurate name, dosage, and reason details)

(Accurate) Name of Medication	Dosage	Reason

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CANCER—BLADDER

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. How was the cancer treated? (check all that apply)

☐ Endoscopic resection only
☐ Endoscopic resection and chemotherapy instilled in the bladder
☐ Radical cystectomy (removal of the bladder)
☐ Radiation therapy

☐ Systemic chemotherapy

3. What stage was the cancer?

☐ Tis ☐ T☐ T☐ T4
☐ Ta ☐ T2 ☐ T3b

4. Has there been any evidence of recurrence?

☐ No ☐ Yes; please give details _____

_____

5. Please give the date and result of the most recent cystoscopy and urine cytology: _____

_____

6. What medications is client taking? (accurate name, dosage, and reason) _____

_____

7. Are there any other health problems? (additional questionnaires may be required) _____

_____

8. Has there been any evidence of recurrence? (if yes, give details) _____

_____

9. Are there any other health problems? ☐ No ☐ Yes; please give details _____

_____

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CANCER—BREAST

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. How was the cancer treated?
☐ Excisional biopsy only
☐ Lumpectomy or wide excision
☐ Mastectomy
☐ Radiation therapy
☐ Chemotherapy
☐ Hormonal therapy (tamoxifen)

3. List date treatment was completed: _____

4. Is client on any medications? ☐ No ☐ Yes; please give details _____

_____

_____

5. What stage was the cancer?
☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

6. Were lymph nodes involved? ☐ No ☐ Yes; If yes, how many? _____

7. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details _____

_____

_____

8. Date and results of last mammogram: _____

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

_____

_____

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CANCER—CERVICAL

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. What stage was the cancer?

☐ Stage 0 (in-situ) ☐ Stage Ia ☐ Stage Ib ☐ Stage II ☐ Stage III ☐ Stage IV

3. How was the cancer treated? (check all that apply)

☐ Cone surgery ☐ Total hysterectomy ☐ Radiation therapy ☐ Chemotherapy

4. Indicate date treatment was completed: _____ / _____ / _____

5. Has there been any evidence of recurrence?

☐ No ☐ Yes; please give details _____

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

_____

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CANCER—OVARIAN

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____ / _____ / _____

2. How was the cancer treated? (check all that apply)

☐ Surgery ☐ Radiation ☐ Chemotherapy

3. What stage was the cancer?

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details _____

_____

_____

5. Please give the date and result of the most recent CA 125 (if available): _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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CANCER—PROSTATE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. What was the pretreatment PSA? _____

3. How was the cancer treated? (check all that apply)

☐ Observation only ☐ TURP (transurethral prostatectomy) ☐ Radical prostatectomy

☐ Radiation therapy (seed implant or external beam radiation

4. What is date and result of the most current PSA test? _____

_____

5. What was the Gleason score? _____

6. What stage was the cancer?

☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

7. Is there a family history of cancer? ☐ No ☐ Yes

8. What medications is client 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

_____

_____

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CANCER—SKIN

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date(s) of diagnoses: _____

2. What was the type of cancer was diagnosed? ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Malignant melanoma

3. Where was the skin cancer located? _____

4. Has the cancer metastasized (spread) beyond the skin?

☐ No ☐ Yes; please give details _____

_____

5. Has there been any evidence of recurrence?

☐ No ☐ Yes; please give details _____

_____

6. For malignant melanoma only, what stage was the cancer?

☐ Clark I/in situ ☐ Clark II/Breslow < 0.75mm ☐ Clark III/Breslow .75–1.5mm ☐ Clark IV/Breslow 1.51–4.0mm
☐ Clark V/Breslow > 4.0mm

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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CANCER—TESTICULAR

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date(s) of diagnoses: _____

2. What was the type of testicular cancer? _____

3. Is there a family history of cancer? ☐ No ☐ Yes; please give details _____

_____

_____

4. How was the cancer treated? ☐ Surgery ☐ Chemotherapy ☐ Radiation therapy

5. Date treatment was completed: _____

6. What stage was the cancer? ☐ Stage 1 ☐ Stage II ☐ Stage III

7. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details _____

_____

_____

8. Please give the date and result of the most recent AFP or HGC test: _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 disabled? ☐ No ☐ Yes; please give details _____

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What is the type of lung disease?

☐ Chronic bronchitis ☐ Emphysema ☐ Restrictive lung disease ☐ Asthma

2. Date first diagnosed: _____

3. Has your client ever been hospitalized for this condition? ☐ No ☐ Yes; please give details _____

_____

4. Has your client ever smoked?

☐ Yes, and currently smokes _____ (amount per day)

☐ Yes, smoked in the past but quit _____ (date quit)

☐ Never smoked

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

(Accurate) Name of Medication	Dosage	Reason

6. Have pulmonary function tests (a breathing test) ever been done? ☐ No ☐ Yes; please give details _____

_____

_____

7. Client's build: Height: _____' _____" Weight: _____

8. Does your client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details _____

_____

9. Does client have any other major health issues (heart disease, etc.)? (additional questionnaires may be required)

☐ No ☐ Yes; please give details _____

_____

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CONGESTIVE HEART FAILURE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. What is the cause of the CHF? _____

3. Has the client had surgical heart repair?

☐ No ☐ Yes; type: _____ Date: _____ / _____ / _____

4. Does client have a history of any of the following? (provide details)

☐ Hypertension _____

☐ Coronary artery disease _____

☐ Chronic obstructive pulmonary disease _____

☐ Pacemaker _____

5. Has an angiogram, echocardiogram, stress test, or heart scan been done?

☐ No ☐ Yes; please give details and provide a copy if available _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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CORONARY ARTERY DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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(s) of diagnosis and type of coronary artery disease: _____

_____

2. Does client's family have any history of heart disease? ☐ No ☐ Yes; list family member(s) and details

_____

_____

_____

_3. Has client had any of the following?:

☐ Heart attack Date: _____
☐ Coronary angioplasty (PTCA) Date: _____
☐ Heart failure Date: _____
☐ Valve surgery Date: _____
☐ Bypass surgery Date: _____

4. Has client had any of the following?:

☐ Abnormal lipid levels
☐ Overweight
☐ High blood pressure
☐ Irregular heart beats
☐ Elevated cholesterol
☐ Diabetes
☐ Elevated homocysteine
☐ Peripheral vascular disease
☐ Cerebrovascular or carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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CORONARY BYPASS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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(s) of diagnosis and type of coronary artery disease: _____

_____

2. Does client's family have any history of heart disease? ☐ No ☐ Yes; list family member(s) and details

_____

_____

3. Has client had any of the following?:

☐ Heart attack Date: _____ / _____ / _____ ☐ Heart failure Date: _____ / _____ / _____

☐ Coronary angioplasty (PTCA) Date: _____ / _____ / _____ ☐ Valve surgery Date: _____ / _____ / _____

4. Number of vessels by-passed? _____

5. How badly were the vessels occluded (percentage)? 0.00%

6. Has a follow-up stress (exercise) ECG been completed since procedure?

☐ No ☐ Yes, Normal Date: _____ / _____ / _____ ☐ Yes, Abnormal Date: _____ / _____ / _____

7. Has client had any chest discomfort since the procedure? ☐ No ☐ Yes; please provide details

_____

_____

8. Has client had any of the following?:

☐ Abnormal lipid levels ☐ Irregular heart beats ☐ Elevated homocysteine ☐ Overweight ☐ Elevated cholesterol

☐ High blood pressure ☐ Diabetes ☐ Peripheral vascular disease ☐ Cerebrovascular or carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

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CROHN'S DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. Blood in stools? ☐ Yes ☐ No

3. What type of treatment is client on?

☐ Diet

☐ Medication—if so, what? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

4. How often does client have attacks? _____

5. Is condition asymptomatic? ☐ Yes ☐ No

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

_____

_____

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CUSHING SYNDROME

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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(s) of diagnosis and type of coronary artery disease: _____

_____

2. What evaluation was done? Please give date and results.

☐ MRI, CT Date: _____ / _____ / _____ ☐ Urine Test Date: _____ / _____ / _____

☐ Blood Test Date: _____ / _____ / _____

3. Has your client ever been hospitalized for Cushing syndrome? ☐ No ☐ Yes; please give details

_____

_____

4. Has your client been prescribed steroids for any other illness? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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DEMENTIA—ALZHEIMER'S

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 the type of dementia: _____

2. Date of onset of symptoms: _____ / _____ / _____ Date of diagnosis: _____ / _ _____ / _____

3. Note functional status:

☐ Minimal cognitive changes, fully functioning
☐ Needs supervision outside the home
☐ Assistance needed on any ADL (Activities of Daily Living)
☐ Custodial care

4. Is there also a history of depression? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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DEPRESSION

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 the diagnosis: _____

2. Please indicate: Number of episodes: _____ Date of last episode: _____

3. Has client been hospitalized for psychiatric treatment? ☐ No ☐ Yes; plesase give dates and lengths of stay.

_____

_____

4. Does client have a history of any of the following associated conditions? Please check all that apply. (Additional questionnaires may be required)

☐ Personality disorder
☐ Psychotic disorder
☐ Suicidal thought/attempt
☐ Substance abuse (alcohol or drugs) (complete questionnaire)
☐ Other psychiatric disorder _____

5. Is the client currently working? ☐ No ☐ Yes; please list occupation

_____

6. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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DIABETES

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date first diagnosed: _____

2. How often does your client visit his/her physician?: _____

   When was the last visit? _____

3. The client's diabetes is controlled by:

☐ Diet alone

☐ Oral medication (medication and doses) _____

☐ Insulin (amount and units/day) _____

4. Please give the most recent blood sugar reading: _____

5. Does client monitor his/her own blood sugar? _____

6. If available, please give the most recent glycohemoglobin (BhA1C) or fructosamine level: _____

7. Please check if your client has (had) any of the following:

☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated lipids

☐ Overweight ☐ Neuropathy ☐ Kidney disease

☐ Retinopathy ☐ Abnormal ECG ☐ Hypertension

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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DOWN SYNDROME / INTELLECTUAL DISABILITY

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What is applicant's IQ? _____

2. Is applicant self-supporting? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

DOWN SYNDROME

1. What is applicant's social and economic situation?

_____

_____

2. Are there any cardiovascular or pulmonary problems? ☐ No ☐ Yes; please give details

_____

_____

INTELLECTUAL DISABILITY

1. At what age did applicant become diagnosed? _____

2. Is the disability chromosomal? ☐ No ☐ Yes; PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE

_____

_____

_____

_____

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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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. In the past 5 years, has client's drivers license been suspended or revoked? ☐ No ☐ Yes; please give details

_____

_____

2. In the past 5 years, has client been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs? ☐ No ☐ Yes; please give details

_____

_____

3. What is applicant's occupation? _____

4. Is applicant married? ☐ No ☐ Yes

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DRUGS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of the initial treatment or diagnosis? _____

2. What is client's: ☐ Martial status: _____ ☐ Occupation: _____
☐ Length of employment: _____

3. Is client an active member of a drug use recovery group? ☐ No ☐ Yes; how long? _____

4. Has client ever joined and then left a drug use recovery group? ☐ No ☐ Yes; please give details

_____

_____

5. What drug(s) were used or abused? (name of drug and dates of usage)

_____

_____

6. Were there any relapses from sobriety/abstinence? ☐ No ☐ Yes; please list dates

_____

_____

7. Has client ever been convicted of any drug-related activity? ☐ No ☐ Yes; please give details

_____

_____

8. Have there been physical complications or additional psychiatric problems? ☐ No ☐ Yes; please give details

_____

_____

9. What is client's current level of alcohol consumption? _____

10. Is client taking any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

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EATING DISORDERS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 give the diagnosis: ☐ Anorexia nervosa ☐ Bulimia nervosa

2. Please indicate the number of episodes and date of last episode/recovery: _____

_____

3. Please note client's current _____ height _____ weight

4. Has weight remained stable for at least 1 year? ☐ No ☐ Yes; please give details

_____

_____

5. Has client been hospitalized for treatment of an eating disorder? ☐ No ☐ Yes; please give details

_____

_____

6. Does client have a history of any of the following associated conditions? (Please check all that apply.)

☐ Substance abuse (alcohol or drugs) Personality disorder

☐ Psychotic disorder Suicidal thought/attempt

☐ Depression Anxiety disorder

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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EMPHYSEMA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What is the cause? ☐ Asthma ☐ Occupation ☐ Smoking

2. What is the degree of severity? _____

3. Does client use oxygen? ☐ No ☐ Yes

4. Has client ever been hospitalized? ☐ No ☐ Yes; please give details

_____

_____

5. Have pulmonary function tests been done? ☐ No ☐ Yes; what were the results?

_____

_____

6. Are there any restrictions of activities? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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ENLARGED HEART

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. When was the condition first diagnosed? _____

2. Have any of the following symptoms occurred?

☐ Chest discomforto
☐ Fainting spells or dizziness
☐ Shortness of breath
☐ Palpitations (irregular heart beat)

3. Please check if your client has had any of the following:

Chest X-ray: ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Exercise treadmill or thallium ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Resting or exercise echocardiogram ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
MUGA ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Cardiac catheterization ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal

4. Is there a history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc.)?

☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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EPILEPSY

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. Indicate the type of seizure:

☐ Complex/partial seizure ☐ Tonic-clonic seizure ☐ Absense seizure ☐ Myoclonic seizure

3. Indicate the number or frequency of episodes and date of last episode: _____

_____

4. Has client been hospitalized for treatment of epilepsy? (give details)

☐ No ☐ Yes; please give details _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

6. What is client's occupation? _____

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

_____

_____

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GLOMERULONEPHRITIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 note type of Glomerulonephritis: _____

2. Please list date of first diagnosis: _____

3. Was a kidney biopsy done? ☐ No ☐ Yes; please give date and diagnosis

_____

_____

4. Please provide the client's most recent readings for:

☐ Blood pressure _____

☐ BUN _____

☐ Creatinine _____

☐ Urinalysis _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HEART ATTACK—MYOCARDIAL INFARCTION

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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(s) of the heart attack(s): _____

2. Has the client had any of the following:

☐ Echocardiogram Date: _____
☐ Coronary catheterization Date: _____
☐ Coronary angioplasty Date: _____
☐ Bypass surgery Date: _____
☐ Heart failure Date: _____
☐ Arrhythmias Date: _____

3. Has a follow-up stress (exercise) ECG been completed since the heart attack? ☐ No ☐ Yes; please give details

_____

_____

4. Please check if your client has had any of the following:

☐ Abnormal lipid levels ☐ Irregular heartbeats* ☐ Peripheral vascular disease*
☐ Overweight ☐ Diabetes; age of onset: _____ ☐ Cerebrovascular or carotid disease
☐ High blood pressure ☐ Elevated homocysteine

*These conditions require an additional questionnaire to be completed, please request.

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HEART FAILURE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What was the cause of heart failure? _____

2. When was the diagnosis made? _____

3. Has client had surgical heart repair? ☐ No ☐ Yes; please give details

_____

_____

4. Does client have a history of any of the following (please provide details or complete the questionnaire for the condition):

☐ Hypertension _____

☐ Coronary artery disease _____

☐ Chronic obstructive pulmonary disease _____

☐ Pacemaker _____

5. Has an angiogram, echocardiogram, stress test, or heart scan been done? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HEART MURMUR

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What type of murmur does client have?

☐ Aortic stenosis ☐ Aortic regurgitation ☐ Aortic insufficiency
☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral insufficiency
☐ Pulmonic stenosis ☐ Flow murmur ☐ Innocent murmur

2. When was the heart murmur first discovered? _____

3. Does client have a history of rheumatic fever? ☐ No ☐ Yes

4. When was the client last seen by a physician for the heart murmur? _____

5. When was the last echocardiogram done? _____ What were the results? _____

_____

6. Was a cardiac catheterization ever done ☐ No ☐ Yes; please give date _____

7. Does client have any symptoms or any limitation of activities? ☐ No ☐ Yes; please give details

_____

_____

8. Has client had any heart surgery or has surgery been discussed? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HEMOCHROMATOSIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. What organs are involved? (check all that apply)

☐ Liver
☐ Pancreas (diabetes)
☐ Joints
☐ Heart
☐ Pituitary

3. When was the last phlebotomy treatment? _____

4. Was a liver biopsy done? ☐ No ☐ Yes; please provide a copy

5. If available, please provide the most recent serum ferritin result:

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HEPATITIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. What type of hepatitis: ☐ A ☐ B ☐ C

3. Was the hepatitis due to:
☐ Hepatitis A ☐ Hepatitis C (non-A/non-B) ☐ Hepatitis B, resolved ☐ Hepatitis B, carrier or chronic infection
☐ Other, please specify _____

4. Please give the date and results of the most recent liver enzyme tests:

☐ AST/SGOT Date: _____ ☐ ALT/SGPT Date: _____ ☐ GGTP Date: _____

Result: _____ Result: _____ Result: _____

5. Does the client drink alcohol? ☐ No ☐ Yes; please give details _____

6. Please check if any of the following studies have been completed:
☐ Liver ultrasound or CT scan ☐ normal / ☐ abnormal
☐ Liver biopsy ☐ normal / ☐ abnormal
☐ No further evaluation

7. Has client been diagnosed with any of the following: ☐ Chronic hepatitis ☐ Cirrhosis

8. Was there any treatment done? ☐ No ☐ Yes; what type? _____

9. When did treatment start _____ and terminate _____?

10. Was treatment successful in eliminating the virus? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HYPERCOAGULABLE DISORDER

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. Please note type of treatment: ☐ Hospitalization Date: _____
☐ Coumadin ☐ Aspirin Heparin

3. Was there a thromboembolic event?
☐ MI ☐ CVA ☐ DVT ☐ PE ☐ Other ☐ None

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HYPERGLYCEMIA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. What were the last 4 levels for:

☐ Glycohemoglobin: _____

☐ Glucose: _____

☐ Microalbumin: _____

3. Is condition controlled? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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HYPERTENSION

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. What was the most recent blood pressure reading? _____

3. Please check any of the below that client has had:

☐ Chest pain or coronary artery disease
☐ Diabetes
☐ Family history of: heart disease, high blood pressure, stroke
☐ Abnormal lipid levels
☐ TIA or stroke
☐ Enlarged heart
☐ Aneurysm
☐ Peripheral vascular disease
☐ Kidney disease
☐ Overweight

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

☐ Yes; normal Date: _____ ☐ Yes; abnormal Date: _____
☐ No

5. Has client ever had an echocardiogram? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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IRREGULAR HEARTBEAT

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date first diagnosed: _____

2. Is the irregular heatbeat due to (check all that apply):

☐ Premature supraventricular atrial beats (PACs)
☐ Premature ventricular beats (PVCs)
☐ Multifocal
☐ Bigeminy or trigeminy
☐ Ventricular tachycardia

3. Are there any symptoms with the irregular heartbeat?

☐ Black-out ☐ Dizziness (lightheadedness)/faint feeling ☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? (If so, please give date and results)

☐ ECG Date: _____ _____
☐ Stress test Date: _____ _____
☐ Echocardiogram Date: _____ _____
☐ Holter monitor Date: _____ _____

5. The cause of the irregular heart beat is due to: ☐ Heart disease ☐ Alcohol ☐ Thyroid disease ☐ Unknown or other _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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KIDNEY FUNCTION TESTS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date first diagnosed: _____

2. Please check if any of these conditions are present (complete questionnaire for each condition checked):

☐ Diabetes
☐ Polycystic kidney disease
☐ Glomerulonephritis
☐ Nephrosclerosis
☐ Systemic lupus erythematosus
☐ Other: _____

3. Give most recent results of kidney function tests:

☐ BUN _____
☐ Serum creatinine _____
☐ Urinalysis _____

4. Have any of the following occurred (check all that apply):

☐ Frequent infection
☐ High blood pressure
☐ Cardiovascular disease (complete questionnaire for this condition)

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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KIDNEY TRANSPLANT

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of the transplant: _____

2. ☐ Single or ☐ multiple transplant?

3. What was the cause of the end stage renal disease which led to the transplant? (Cause for the transplant)

☐ Diabetes ☐ Glomerulonephritis ☐ Nephrosclerosis ☐ Systemic lupus erythematosus

☐ Polycystic kidney disease ☐ Other: _____

4. What was the source of the donor kidney?

☐ Cadaver ☐ Living related donor ☐ Identical twin ☐ Other: _____

5. Please give most recent results of kidney function tests:

☐ BUN _____

☐ Serum creatinine _____

☐ Urinalysis _____

6. Have any of the following occurred (check all that apply):

☐ Frequent infection ☐ Rejection episodes ☐ Toxicity from treatment ☐ High blood pressure

☐ Cardiovascular disease ☐ Cancer ☐ Disease recurrence

7. How often are checkups? _____

8. Are there any disabilities since the transplant? ☐ No ☐ Yes; please give details

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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LEUKEMIA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. What is the current stage of the leukemia?

☐ Stage 0 ☐ Stage 1 ☐ Stage II ☐ Stage III ☐ Stage IV

3. Please provide results of the most recent CBC (complete blood count):

☐ Date _____

☐ Hemoglobin _____

☐ White blood cell count _____

☐ Platelet count _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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LIVER TESTS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

1. How long has this abnormality (elevated liver enzymes) been present? _____

2. Please give the date and results of the most recent liver enzyme tests.

a) AST/SGOT Date: _____ _____

b) ALT/SGPT Date: _____ _____

c) GGTP Date: _____ _____

d) ALP Date: _____ _____

e) Billirubin Date: _____ _____

3. Have these results been

☐ Increasing

☐ Decreasing

☐ Fluctuating up and down

☐ Stable

☐ Unknown

4. Does client drink alcohol? (answer all that apply)

☐ No ☐ Yes; please note amount and frequency _____

☐ Drinking pattern changed recently _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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LUNG DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. Type of lung disease:
☐ Interstitial lung disease; type _____
☐ Chronic bronchitis
☐ Emphysema
☐ Asthma

3. Was a biopsy done? ☐ No ☐ Yes

4. Has client improved since diagnosis? ☐ No ☐ Yes

5. Has client ever been hospitalized for this condition? ☐ No ☐ Yes; please give details

_____

_____

6. Has client ever smoked?
☐ Yes; currently smokes _____ (amount/day)
☐ Yes; smoked in the past but quit _____ (date)
☐ Never smoked

7. Have pulmonary function tests (breathing test) ever been done? ☐ No ☐ Yes; please give most recent test results

_____

_____

8. Does client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

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LUPUS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. Type of lupus diagnosed?:
☐ Systemic lupus erythematosus (SLE)
☐ Discord lupus
☐ Drug-induced SLE

3. Please note if the lupus is:

☐ in remission (list date of last exacerbation) Date: _____ _____

☐ currently present

4. Check if client has had any of the following:
☐ Low blood counts ☐ Neurologic disorder
☐ Lung involvement (pleuritis) ☐ Heart involvement (pericarditis)
☐ Proteinuria ☐ Renal insufficiency or failure
☐ High blood pressure

5. Is client presently on medication? (accurate name, dosage, and reason)) ☐ No ☐ Yes; please give details

_____

_____

6. What type of treatment has client had? _____

7. When was treatment terminated? _____

8. Have steroids ever been prescribed? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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LYMPHOMA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnoses: _____

2. Indicate the type of lymphoma:

☐ Hodgkin's Lymphoma __Non-Hodgkin's Lymphoma—low grade

☐ Non-Hodgkin's Lymphoma—intermediate-grade

☐ Non-Hodgkin's Lymphoma—high grade

3. What was the staging at the time of diagnosis?

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

4. Please note if any of the following were present at time of diagnosis (check all that apply):

☐ Type B symptoms (fever, weight loss, and/or night sweats)

☐ Large mediastinal (chest) disease (tumor > 7.5 cm)

☐ Elevated LDH (blood test)

☐ More than 1 extranodal site involved

5. What treatment did client receive? (check all that apply)

☐ Chemotherapy ☐ Radiation ☐ Surgery

What was the date of the last treatment? _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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MENTAL DISORDERS

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Describe client's condition. Give the diagnosis.

_____

_____

2. Date of first symptoms? _____

3. When did client last see doctor for this condition? _____

4. Has client been hospitalized ☐ No ☐ Yes; (list all)

Date: _____ _____

Date: _____ _____

5. Is client currently employed? ☐ No ☐ Yes

6. Has condition interfered with work? ☐ No ☐ Yes, If so, how long? _____

7. Is client disabled? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

9. When was the last medication adjustment made?

Details _____

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

_____

_____

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MITRAL VALVE DISORDER

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. How long has this abnormality been present? _____

2. Please check the type(s) of valve disorder present:

☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral valve prolapse

3. Have any of the following occurred?

Chest pain ☐ No ☐ Yes

Trouble breathing ☐ No ☐ Yes

Heart failure ☐ No ☐ Yes

Palpitations ☐ No ☐ Yes

Atrial fibrillation/flutter ☐ No ☐ Yes

4. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease, etc.)? ☐ No ☐ Yes; please give details

_____

_____

5. Have additional studies been completed? (check all that apply)

☐ Echocardiogram Date: _____

☐ Cardiac catheterization Date: _____

☐ None

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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MITRAL VALVE PROLAPSE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. How long has this abnormality been present? _____

2. Have any of the following symptoms occurred? (check all that apply)

Fainting or dizziness	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?

☐ No ☐ Yes; please submit a copy of the report

_____

_____

4. Has an echocardiogram (ultrasound of the heart) been done? ☐ No ☐ Yes; please submit a copy of the report

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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MULTIPLE SCLEROSIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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: _____

2. Indicate number of episodes: _____

3. Date of last episode: _____

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

☐ Normal

☐ Minimal residual impairment (please specify) _____

☐ Moderate residual impairment (please specify) _____

☐ Severe residual impairment (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

_____

_____

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NEUROMUSCULAR DISORDER

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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: _____

2. Name of neuromuscular disorder: _____

3. Describe condition with diagnosis. _____

_____

4. What is your condition? _____

_____

5. Is client disabled?) ☐ No ☐ Yes

6. Does client use a cane or a wheelchair? ☐ No ☐ Yes

7. Does client have a caregiver? ☐ No ☐ Yes

6. Is client receiving any treatment? ☐ No ☐ Yes, What type? _____

9. When did client last see doctor for this condition? _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PACEMAKER

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date the pacemaker was implanted: _____

2. The pacemaker was implanted for:

☐ Heart block associated with coronary artery disease
☐ Complete heart block or sick sinus syndrome
☐ Chronic underlying atrial flutter/fibrillation
☐ Other; give details _____

3. Does client have another heart disease? Give details:

_____

4. Have any of the following pacemaker complications occurred?

☐ Infection ☐ Blood clots ☐ Pacemaker malfunction ☐ Perforation

☐ Other; please give details _____

5. Are there any continuing symptoms since the pacemaker was implanted? ☐ No ☐ Yes; please give details

_____

_____

6. When was client's last checkup? _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PANCREATITIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 the date when first diagnosed: _____

2. What type of pancreatic disorder was diagnosed?

☐ Cyst, Pseudocyst ☐ Abscess ☐ Pancreatitis ☐ Stone

☐ Other; please give details _____

3. Was client incapacitated from work due to the pancreatic disorder? ☐ No ☐ Yes; when and for how long

_____

_____

4. Was client hospitalized? ☐ No ☐ Yes; (give dates and how long below)

Date: _____ Duration _____

Date: _____ Duration _____

Date: _____ Duration _____

5. Was any surgery performed? ☐ No ☐ Yes; please give details

_____

_____

6. If pancreatitis, describe frequency of attacks and date of most recent attack:

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PANHYPOPITUITARISM

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. When was client diagnosed with pituitary dysfunction? _____

2. What was the cause of the pituitary dysfunction? _____

_____

3. What kind of hormone replacement therapy is required? _____

_____

4. Please list dates of any hospitalizations, radiation treatments, or surgeries. If there was a tumor, please provide a pathology report and the results of any scans.

Date: _____ _____

Date: _____ _____

Date: _____ _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PARALYSIS—SIMILAR PHYSICAL DISABILITY

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date disability occured? _____

2. What was the cause (e.g., congenital, injury, polio)?

_____

_____

3. What parts of the body are affected?

_____

_____

4. Does client have limitations in walking, driving, speech or other activities? ☐ No ☐ Yes

5. Has surgery been performed or planned? ☐ No ☐ Yes

6. Has client's bowel or bladder function been affected? ☐ No ☐ Yes

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

_____

_____

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PARKINSON'S DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosed: _____

2. Please note the functional stage of the client currently:

☐ Stage I unilateral involvement
☐ Stage II bilateral involvement but normal stance
☐ Stage II bilateral involvement with mild postural imbalance, but able to lead an independent life
☐ Stage IV bilateral involvement with postural instability; requires substantial help
☐ Stage V severe disease; restricted to bed or wheelchair

3. Has there been any evidence of progression? ☐ No ☐ Yes; please give details

_____

_____

5. Please note if any of the following have occurred (check all that apply):

☐ Dementia ☐ Recurrent infections
☐ Memory problems ☐ Falls
☐ Aspiration ☐ Recurrent injuries
☐ Pneumonia ☐ Depression

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PERSONALITY DISORDERS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis? _____

1. Please note which type of personality disorder has been diagnosed:

☐ Antisocial ☐ Narcissistic
☐ Borderline ☐ Histrionic
☐ Paranoid ☐ Dependent
☐ Schizoid ☐ Obsessive/Compulsive
☐ Schizotypical ☐ Avoidant

3. Has client been hospitalized for a psychiatric illness? ☐ No ☐ Yes; please give dates and details

_____

_____

4. Does your client have any of the following associated conditions?

Substance abuse (alcohol or drugs): ☐ No ☐ Yes; please give details _____
Mood disorder (e.g., depression): ☐ No ☐ Yes; please give details _____
Suicidal thought/attempt: ☐ No ☐ Yes; please give details _____
Other psychiatric disorder: ☐ No ☐ Yes; please give details _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PHEOCHROMOCYTOMA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis? _____

☐ Benign vs. ☐ Malignant

☐ Single vs. ☐ Multiple

2. What evaluation was done? Please give date and results.

☐ MRI, CT Date: _____ _____

☐ Urine Test Date: _____ _____

☐ Blood Test Date: _____ _____

3. Has your client had surgery to remove a pheochromocytoma? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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POLYCYSTIC KIDNEY DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Do any other family members have ADPKD? ☐ No ☐ Yes; please give details

_____

_____

2. Was ADPKD diagnosed by ultrasound? ☐ No ☐ Yes

3. What are your current blood pressure readings? ☐ No ☐ Yes

4. Please provide the results and date of your most recent urinalysis.

Protein _____

Red blood cell (RBC) _____

White blood cell (WBC) _____

Protein/creatinine ratio _____

5. Please provide the date and results of the most recent kidney function tests.

BUN Date: _____ _____

Serum Creatinine Date: _____ _____

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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POLYP, CYST, TUMOR, OR GROWTH

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What type of growth did client have? _____

2. When was it discovered? Date: _____

3. What is the specific location in or on the body where it is located?

_____

_____

4. How many were present or removed? _____

5. What type of treatment has client had? _____

_____

6. If removed surgically, what was the pathological diagnosis? ☐ Benign ☐ Malignant

If you have pathology report available, please provide it.

7. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PROSTATE BENIGN

(BENIGN PROSTATIC HYPERTROPHY AND PROSTATITIS)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date when first diagnosed: _____

2. If any of the following have been done, please give details and result(s):

☐ Bladder catheterization _____

☐ Prostate biopsy _____

☐ Prostate ultrasound _____

☐ TURP (transurethral prostatectomy) _____

3. Please give result and date of most recent PSA test:

Date: _____ _____

4. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PROTEINURIA (PROTEIN IN URINE)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. How long has this abnormality been present? _____years
2. Has a specific cause for the proteinuria been found? ☐ No ☐ Yes; please give details

_____

_____

3. Give the date and results of the most recent urinalysis:
   - a. Protein Date: _____ _____
   - b. Red blood cells (RBCs) Date: _____ _____
   - c. White blood cells (WBCs) Date: _____ _____
   - d. Protein/creatinine ratio Date: _____ _____
4. Give the dates and results of the most recent kidney function tests:
   - a. BUN Date: _____ _____
   - b. Serum creatinine Date: _____ _____
5. If any of the following urinary tests have been completed, give the date and result:
   - a. Microalbumin Date: _____ _____
   - b. 24-hr. protein Date: _____ _____
   - c. 24-hr. creatinine clearance Date: _____ _____
   - d. Other: _____ Date: _____ _____
6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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PSA—ELEVATED

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. How long has the PSA been elevated? _____

2. What is the diagnosis? _____

3. Please give the date and result(s) of all recorded PSA value(s):

4. Have these results been
☐ Increasing
☐ Decreasing
☐ Stable
☐ Fluctuating up and down
☐ Unknown

5. If any of the following have been done, please give the details and result(s):

☐ TRUS _____

☐ PSAD _____

☐ Free PSA _____

☐ Prostate biopsy _____

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SARCOIDOSIS

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

2. Was a biopsy done? ☐ No ☐ Yes

3. Stage: _____

4. How was the sarcoid treated? ☐ No treatment ☐ Prednisone

5. Date treatment was completed: _____

6. What organs were involved? (check all that apply)

☐ Lung ☐ Kidney ☐ Heart ☐ Central nervous system

☐ Liver or spleen ☐ Skin ☐ Eyes ☐ Lymph nodes

8. Give results of the most recent pulmonary function tests:

FVC _____

FEV1 _____

9. Has there been any evidence of recurrence/progression? ☐ No ☐ Yes; please give details

_____

_____

10. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SCLERODERMA / CREST

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 note type of scleroderma:

☐ Localized scleroderma-morphea or linea
☐ Limited scleroderma/CREST
☐ Progressive systemic sclerosis-diffuse scleroderma

2. Please list date of first diagnosis: _____

3. Please check if client has had any of the following:

☐ Weight loss ☐ Biliary cirrhosis
☐ Heart disease ☐ Liver enzyme abnormality
☐ Lung disease ☐ Kidney disease
☐ Reyaud's disease ☐ Trouble swallowing

5. Please list functional ability:

☐ Fully active
☐ Sedentary
☐ Uses walker, cane, etc.
☐ Uses wheelchair

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SEIZURE DISORDER (EPILEPSY)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of first diagnosis: _____

1. When did client have the first and last attack? _____

2. Are the attacks ☐ grand mal or ☐ petit mal in character?

3. What is the frequency of the attacks? _____

_____

4. What type of treatment is indicated? _____

_____

5. When did client last see his/her physician for this condition?

_____

_____\

6. What is client's occupation?

_____

7. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SICKLE CELL ANEMIA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. What type of sickle cell anemia does client have?

☐ Sickle cell (SS)
☐ Sickle cell (SC)
☐ Sickle cell trait (SA)
☐ Hemoglobin C

3. Is there a history of complications? ☐ No ☐ Yes; please check those that apply and give the date of the last episode.

☐ Painful crisis Date: _____
☐ Aaseptic necrosis of bones Date: _____
☐ Leg ulcers Date: _____
☐ Lung scarring Date: _____
☐ Thrombosis Date: _____
☐ Enlarged heart Date: _____
☐ Other: _____ Date: _____

4. What is the current hemoglobin? _____

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SLEEP APNEA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. Was the sleep apnea diagnosed as:

☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. How is the sleep apnea being treated?

Observation alone

☐ Weight loss

☐ CPAP mask; if CPAP given, date use was terminated: _____

☐ Surgery; Date of surgery: _____

☐ Other; please give details _____

4. If surgery was done, was sleep apnea corrected? ☐ No ☐ Yes; please give details

_____

_____

5. Has client had any of the following?

☐ lung disease ☐ overweight ☐ chest pain or coronary artery disease

☐ depression ☐ stroke ☐ arrhythmia

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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SPINAL CORD INJURY (PLEGIC)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. At what spinal cord level was the injury? (list specific vertebrae, if available)

☐ Cervical spine _____

☐ Thoracic spine _____

☐ Lumbrosacral spine _____

3. Note current level of function:

☐ Incomplete paraplegia ☐ Complete paraplegia

☐ Incomplete quadriplegia ☐ Complete quadriplegia

4. Have any of the following occurred? (check all that apply)

☐ Pneumonia

☐ Skin ulcers

☐ Urinary tract infection

☐ Kidney impairment

☐ Depression

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. When and where was the stent put in? _____

2. What type of stent was put in? _____

3. Why was the stent put in? _____

_____

4. How many vessels were involved?_____

5. Has the applicant had an imaged stress test done? ☐ No ☐ Yes; if yes, when and what were the results?

_____

_____

6. What type of follow-up testing has been done and what were the results? _____

_____

7. Was there a heart attack prior to the stent being put in? ☐ No ☐ Yes;

8. Is there family history of heart disease? ☐ No ☐ Yes; please give details

_____

_____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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STROKE, TIA

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date(s) of the episode(s)? _____

2. Were any of the following studies completed?

☐ Carotid ultrasound Date: _____

☐ Head CT scan or MRI scan Date: _____

☐ Echocardiogram Date: _____

3. Was client hospitalized ☐ No ☐ Yes; please give details

_____

4. When did client last see their doctor for evaluation? _____

5. Please check any of the of the following that your client has had:

☐ elevated cholesterol ☐ Stroke ☐ diabetes ☐ heart attack

☐ high blood pressure ☐ peripheral vascular disease ☐ coronary artery disease

6. Has surgery ever been done on any carotid artery(ies)? ☐ No ☐ Yes; please give details

_____

7. Give the date and result of the most recent blood pressure readings: Date: _____ _____

8. Are there any residuals (limitation of movement, speech, or vision)? ☐ No ☐ Yes; please give details

_____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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THROMBUS (HYPERCOAGULABLE CLOTTING DISORDER)

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. Note the type of treatment:

☐ Coumadin
☐ Aspirin
☐ Heparin
☐ Hospitalization Date: _____

3. Was there a Thromboembolic event?

☐ MI
☐ DVT
☐ CVA
☐ PE
☐ Other _____
☐ None

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

_____

_____

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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THYROID DISEASE

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. Date of diagnosis: _____

2. Was the thyroid disease diagnosed as (more than one is possible)?

☐ Goiter
☐ Thyroid nodule
☐ Hyperthyroidism
☐ Hypothyroidism

3. How is the thyroid disease being treated?

☐ Surgery
☐ Radioactive iodine
☐ Medication

Please give details: _____

_____

4. Has a biopsy or fine needle aspiration (FNA) been done? ☐ No ☐ Yes; please provide a copy of the report.

5. Has client had an ultrasound or radioactive scan of the thyroid? ☐ No ☐ Yes; please provide a copy of the report.

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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T WAVE CHANGES

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. How long has this abnormality been present? _____

2. Has there been any recent change in the ECG (last 12 month)? ☐ No ☐ Yes; please give details

_____

_____

3. Please check if your client has had any of the following: (check all that apply)

a) Chest pain, coronary artery disease, or other cardiovascular impairment ☐ No ☐ Yes; please give details

_____

_____

b) diabetes ☐ No ☐ Yes

c) elevated cholesterol ☐ No ☐ Yes

d) high blood pressure ☐ No ☐ Yes

4. Have any other studies been completed?

a) exercise treadmill or thallium: ☐ No ☐ Yes, normal ☐ Yes, abnormal

b) resting or exercise echocardiogram: ☐ No ☐ Yes, normal ☐ Yes, abnormal

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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VALVULAR HEART SURGERY

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 **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. When was the surgery completed? _____

2. Please note type of valve surgery:

☐ Valve replacement ☐ Valvuloplasty

☐ Commissurotomy ☐ Other _____

3. Please check the type (s) of valve disorder:

☐ Aortic stenosis ☐ Mitral stenosis ☐ Mitral valve prolapse

☐ Aortic insufficiency ☐ Mitral insufficiency

4. Please note type of valve used if replaced:

☐ Prosthetic (mechanical) ☐ Tissue (porcine or pig)

5. Have any of the following occurred?

☐ Chest pain ☐ Heart failure ☐ Palpitations ☐ Dizziness/fainting ☐ Trouble breathing

6. Is there a history of any other disease in addition to the valve disorder (coronary artery disease, etc.)? ☐ No ☐ Yes; please give details

_____

_____

7. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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