

**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