



# 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

\_\_\_\_\_