

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
 Schizotypal 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