

**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: \_\_\_\_\_
- Aseptic 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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