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 ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

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

_____

_____

_____

