CANCER—TESTICULAR

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?

1. Date(s) of diagnoses: _____

2. What was the type of testicular cancer? _____

3. Is there a family history of cancer? ☐ No ☐ Yes; please give details _____

_____

_____

4. How was the cancer treated? ☐ Surgery ☐ Chemotherapy ☐ Radiation therapy

5. Date treatment was completed: _____

6. What stage was the cancer? ☐ Stage 1 ☐ Stage II ☐ Stage III TNM stage: _____

7. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details _____

_____

_____

8. Please give the date and result of the most recent AFP or HGC test: _____

_____

9. Is client on any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

