Diverticular disease:

1. Does the client have current symptoms? ___ Yes ___ No
   a. Please specify symptoms: _____

2. Has the client had symptoms in the past? ___ Yes ___ No
   a. Please specify date of last symptoms: _____
   b. Please specify symptoms: _____

3. Has the client had surgery for diverticular disease in the past? ___ Yes ___ No
   a. Specify date: _____

4. Is surgery planned in the future for diverticular disease? ___ Yes ___ No

5. Have there been any complications from diverticular disease?
   _____ GI bleeding _____ Abscess _____ Fistula
   _____ Bowel obstruction _____ Perforation _____ Anemia
   _____ Malabsorption _____ Colitis _____ Other (please specify:_____)

   Date(s) of complications: _____

6. Has any other treatment been required now or in the past? ___ Yes ___ No
   a. Please specify: _____

7. Any other health conditions? ___ Yes ___ No
   a. Please specify: _____

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?