

**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?

- How long has the PSA been elevated? \_\_\_\_\_
- What is the diagnosis? \_\_\_\_\_
- Please give the date and result(s) of all recorded PSA value(s):  
 \_\_\_\_\_
- Have these results been  
 Increasing  
 Decreasing  
 Stable  
 Fluctuating up and down  
 Unknown
- If any of the following have been done, please give the details and result(s):  
 TRUS \_\_\_\_\_  
 PSAD \_\_\_\_\_  
 Free PSA \_\_\_\_\_  
 Prostate biopsy \_\_\_\_\_

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details  
 \_\_\_\_\_  
 \_\_\_\_\_