

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 the episode(s)? _____

2. Were any of the following studies completed?

- Carotid ultrasound Date: _____
 Head CT scan or MRI scan Date: _____
 Echocardiogram Date: _____

3. Was client hospitalized No Yes; please give details

4. When did client last see their doctor for evaluation? _____

5. Please check any of the of the following that your client has had:

- elevated cholesterol Stroke diabetes heart attack
 high blood pressure peripheral vascular disease coronary artery disease

6. Has surgery ever been done on any carotid artery(ies)? No Yes; please give details

7. Give the date and result of the most recent blood pressure readings: Date: _____

8. Are there any residuals (limitation of movement, speech, or vision)? No Yes; please give details

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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