

**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 **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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. What type of cancer was diagnosed? \_\_\_\_\_

2. List date of first diagnosis: \_\_\_\_\_

3. Is there a family history of cancer?

No  Yes; please give details \_\_\_\_\_

4. How was the cancer treated?

Surgery  Chemotherapy  Radiation therapy  Hormonal therapy  Immunotherapy  
 Other (give full details)

5. List date treatment was completed: \_\_\_\_\_

6. What was the stage and grade of the cancer? \_\_\_\_\_

7. Has there been any evidence of reoccurrence?  No  Yes; please give details \_\_\_\_\_

8. What did the pathology report reveal? \_\_\_\_\_

9. What medications is client taking? (accurate name, dosage, and reason details)

(Accurate) Name of Medication	Dosage	Reason