

**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. List date(s) of diagnosis and type of coronary artery disease: \_\_\_\_\_

2. What evaluation was done? Please give date and results.

MRI, CT Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Urine Test Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Blood Test Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. Has your client ever been hospitalized for Cushing syndrome?  No  Yes; please give details

4. Has your client been prescribed steroids for any other illness?  No  Yes; please give details

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

(Accurate) Name of Medication	Dosage	Reason

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