

**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. Date of the initial treatment or diagnosis? \_\_\_\_\_

2. What is client's:  Martial status: \_\_\_\_\_  Occupation: \_\_\_\_\_

Length of employment: \_\_\_\_\_

3. Is client an active member of a drug use recovery group?  No  Yes; how long? \_\_\_\_\_

4. Has client ever joined and then left a drug use recovery group?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

5. What drug(s) were used or abused? (name of drug and dates of usage)

\_\_\_\_\_

\_\_\_\_\_

6. Were there any relapses from sobriety/abstinence?  No  Yes; please list dates

\_\_\_\_\_

\_\_\_\_\_

7. Has client ever been convicted of any drug-related activity?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

8. Have there been physical complications or additional psychiatric problems?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

9. What is client's current level of alcohol consumption? \_\_\_\_\_

10. Is client taking any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

\_\_\_\_\_