



# PARALYSIS—SIMILAR PHYSICAL DISABILITY

**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 disability occurred? \_\_\_\_\_

2. What was the cause (e.g., congenital, injury, polio)?

\_\_\_\_\_  
\_\_\_\_\_

3. What parts of the body are affected?

\_\_\_\_\_  
\_\_\_\_\_

4. Does client have limitations in walking, driving, speech or other activities?  No  Yes

5. Has surgery been performed or planned?  No  Yes

6. Has client's bowel or bladder function been affected?  No  Yes

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

\_\_\_\_\_  
\_\_\_\_\_