

**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 diagnosis? \_\_\_\_\_

Benign vs.  Malignant

Single vs.  Multiple

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

MRI, CT Date: \_\_\_\_\_

Urine Test Date: \_\_\_\_\_

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

3. Has your client had surgery to remove a pheochromocytoma?  No  Yes; please give details

4. List all medications client is taking. (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
|                               |        |        |
|                               |        |        |
|                               |        |        |

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