

**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

**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 arthritis is it? (Example: rheumatoid, osteo, gouty, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. When was it initially diagnosed? \_\_\_\_\_

3. Are the joints involved?  No  Yes

4. What is the type of treatment, and does it include cortisone?  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Please list current medications, (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason