**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? |
| | | | |
| | | | |

❑ Yes: Increase __________ lbs. Decrease __________ lbs.

❑ No

1. Has client ever had any weight reduction surgery? ❑ No ❑ Yes; please give details

______________________________________________

______________________________________________

______________________________________________

2. Please check if your client has had any of the following: (If any of the listed is checked off, request the specific questionnaire)
   - ❑ Coronary artery disease
   - ❑ Diabetes
   - ❑ High blood pressure
   - ❑ Elevated cholesterol or triglycerides (lipid Levels)

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

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

4. Has a stress electrocardiogram (treadmill test) been completed within the past year?
   - ❑ Yes—normal Date:
   - ❑ Yes—abnormal Date:
   - ❑ No

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

______________________________________________

______________________________________________

______________________________________________