

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. When was the condition first diagnosed? _____

2. Have any of the following symptoms occurred?

- Chest discomfort
- Fainting spells or dizziness
- Shortness of breath
- Palpitations (irregular heart beat)

3. Please check if your client has had any of the following:

- Chest X-ray: No Yes, Normal / Yes, Abnormal
- Exercise treadmill or thallium No Yes, Normal / Yes, Abnormal
- Resting or exercise echocardiogram No Yes, Normal / Yes, Abnormal
- MUGA No Yes, Normal / Yes, Abnormal
- Cardiac catheterization No Yes, Normal / Yes, Abnormal

4. Is there a history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc.)?

- No Yes; please give details

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

(Accurate) Name of Medication	Dosage	Reason

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