

**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. Please give the diagnosis:  Anorexia nervosa  Bulimia nervosa

2. Please indicate the number of episodes and date of last episode/recovery: \_\_\_\_\_

3. Please note client's current \_\_\_\_\_ height \_\_\_\_\_ weight

4. Has weight remained stable for at least 1 year?  No  Yes; please give details

5. Has client been hospitalized for treatment of an eating disorder?  No  Yes; please give details

6. Does client have a history of any of the following associated conditions? (Please check all that apply.)

Substance abuse (alcohol or drugs) Personality disorder

Psychotic disorder Suicidal thought/attempt

Depression Anxiety disorder

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

(Accurate) Name of Medication	Dosage	Reason

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