ALCOHOL USAGE

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. Does client presently consume alcoholic beverages? ☐ No ☐ Yes, If yes, please list
   - ☐ Beer: Quantity __________ oz. per day ☐ week ☐ month (select one)
   - ☐ Wine: Quantity __________ oz. per day ☐ week ☐ month (select one)
   - ☐ Liquor: Quantity _________ oz. per day ☐ week ☐ month (select one)
2. What was the date of initial treatment or diagnosis? __________ / _________ / _________
3. Were there any relapses from sobriety/abstinence? ☐ No ☐ Yes; please provide details and dates

____

____

____

4. Were there any legal problems (such as DUI) or other? ☐ No ☐ Yes; please provide details and dates
5. Have there been physical complications or additional psychiatric problems? ☐ No ☐ Yes; please provide details and dates, including use of other substances such as marijuana or cocaine

____

____

____

6. Does client currently participate in a group such as Alcoholics Anonymous? ☐ No ☐ Yes
7. Please list current medications (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

8. What is client's: Martial status: ______________________________

Occupation: ______________________________ Length of employment: ______________________

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

____

____

ANGIOPLASTY

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. List the date(s) of the angioplasty (PTCA): ____________
2. How many vessels required the procedure? ____________
3. Why was an angioplasty done? (give specific details)

____

____

____

4. Does client's family have any history of heart disease? ☐ No ☐ Yes
5. Has client had either of the following? ☐ Heart attack __________ (date) ☐ Bypass surgery __________ (date)
6. Has a follow-up stress (exercise) ECG been completed since procedure?

☐ Yes. normal __________ (date) ☐ Yes. abnormal __________ (date) ☐ No

7. Has client had any chest discomfort since the procedure? ☐ No ☐ Yes; please give details

____

____

____

8. Has client had any of the following?

☐ abnormal lipid levels ☐ diabetes ☐ overweight ☐ elevated homocysteine ☐ high blood pressure
☐ peripheral vascular disease ☐ irregular heart beats ☐ cerebrovascular ☐ carotid disease

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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

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ANXIETY DISORDERS

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. Date of diagnosis: ____________

2. ☐ Generalized anxiety disorder ☐ Panic disorder
   ☐ Obsessive compulsive disorder ☐ Post-traumatic stress syndrome
   ☐ Agoraphobia ☐ Other anxiety disorder ____________

3. Indicate the number of episodes and date of last episode/recovery:

4. Is client on any medications: ☐ No ☐ Yes; please provide name and dosage ____________

5. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness? ☐ No ☐ Yes, please give dates and lengths of stay. ____________

6. Does client have a history of any of the following associated conditions? (check all that apply)
   ☐ Depression ☐ Suicidal thought/attempt
   ☐ Substance abuse (alcohol or drugs) ☐ Other psychiatric disorder ____________

7. Is the client currently working? ☐ No ☐ Yes (occupation)____________

8. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give full details

____
____
____

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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

____
____
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ARTHRITIS

NAILBA
NAILBA University

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

ATRIAL FIBRILLATION

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. Date of first diagnosis: ____________________

2. Is the atrial fibrillation/flutter: ☐ Chronic (permanent) ☐ Proxysmal (intermittent)

3. Are there any symptoms with the irregular heart beat?
   ☐ Black-out ☐ Dizziness (light-headedness)/faint feeling
   ☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:
   ☐ ECG ____________________
   ☐ Stress test ____________________
   ☐ Echocardiogram ____________________
   ☐ Holter monitor ____________________

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

(Accurate) Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:
   ☐ Coronary heart disease ☐ Alcohol
   ☐ Thyroid disease ☐ Cardiomyopathy
   ☐ Mitral valve disease ☐ Unknown
   ☐ Other, give details ____________________

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

____

____

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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?

MOUNTAIN CLIMBING

Kind of climbing: ☐ Mountain ☐ Rock ☐ Trail ☐ Ice Years of experience: ______________

Number of climbs in the last 24 months: __________ Number of climbs in the next 12 months: __________

Climbs Outside the Continental U.S.	Date	Climbs Inside the Continental U.S.	Date

UNDERWATER DIVING

How long have you been diving? _______ yrs. _______ mth(s). What certification(s) do you hold? ______________

What kind of equipment do you use? ______________ Do you ☐ Cave ☐ Wreck ☐ Salvage dive? ☐ No

Dive Depths	During the Past 12 Months		Contemplated in the Next 12 Months	
Under 75 ft.				
76 ft. to 150 ft.				
150 ft. or deeper				

SKY DIVING

What kind of license do you hold? ______________ How many jumps have you logged? _______

What events do you participate in? Please explain: ______________

Do you jump professionally or use experimental equipment? Please explain: ______________

Number of jumps in the last 24 months: __________ Number of jumps in the next 12 months: __________

HANG GLIDING, ULTRA LIGHT FLYING, AND HOT AIR BALLOONS

Type of craft flown ______________ Type of terrain ______________

Number of flights in the next 12 months:__________ Maximum flight altitude:__________

Do you participate in competitive or stunt events? ☐ No ☐ Yes Are you a licensed pilot? ☐ No ☐ Yes

What certification(s) do you hold? ______________

With the avocation above, do you belong to any organized clubs? ☐ No ☐ Yes, please list ______________

Additional notes:

____

____

BUILD

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

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BUNDLE BRANCH BLOCK

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. Please check type of BBB present:
   ☐ CLBBB ☐ CRBBB ☐ LAHB or LPHB ☐ IRBBB ☐ Bifascicular block
2. How long has this abnormality been present? _________ (years)
3. Has there been any recent change in the ECG? ☐ No ☐ Yes; please give details

____

____

____

4. Please check if your client has had any of the following: (check all that apply)
   ☐ Chest pain or coronary artery disease
   ☐ Cardiomyopathy
   ☐ High blood pressure
   ☐ Congenital heart disease
   ☐ Valvular heart disease
5. Have any cardiac studies been completed?
   a. Exercise treadmill or thallium: ☐ No ☐ Yes—normal ☐ Yes—abnormal
   b. Resting or exercise echocardiogram: ☐ No ☐ Yes—normal ☐ Yes—abnormal
   c. Other: ☐ No ☐ Yes—normal ☐ Yes—abnormal
6. Is your client on any medications? (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

7. Does your client have any other major health problems? (ex: cancer, etc.) ☐ No ☐ Yes; please give details

____

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____

CANCER

NAILBA
NAILBA University

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 cancer was diagnosed? ______________________

2. List date of first diagnosis: ______________

3. Is there a family history of cancer? ☐ No ☐ Yes; please give details

____

____

____

4. How was the cancer treated?

   ☐ Surgery ☐ Chemotherapy ☐ Radiation therapy ☐ Hormonal therapy ☐ Immunotherapy

   ☐ Other (give full details):______________________

5. List date treatment was completed: ______________

6. What was the stage and grade of the cancer? ______________________

7. Has there been any evidence of reoccurrence? ☐ No ☐ Yes; please give details

____

____

____

8. What did the pathology report reveal?

____

____

____

9. What medications is client taking? (accurate name, dosage, and reason details)

(Accurate) Name of Medication	Dosage	Reason

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CANCER—BLADDER

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. Date of diagnoses: ______________

2. How was the cancer treated? (check all that apply)
   - ☐ Endoscopic resection only
   - ☐ Radical cystectomy (removal of the bladder)
   - ☐ Systemic chemotherapy
   - ☐ Endoscopic resection and chemotherapy instilled in the bladder
   - ☐ Radiation therapy

3. What stage was the cancer?
   - ☐ Tis ☐ T ☐ T4
   - ☐ Ta ☐ T2 ☐ T3b

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

5. Please give the date and result of the most recent cystoscopy and urine cytology:

6. What medications is client taking? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required)

8. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

9. Are there any other health problems? ☐ No ☐ Yes; please give details

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CANCER—BREAST

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. Date of diagnoses: ____________

2. How was the cancer treated?
   - ☐ Excisional biopsy only
   - ☐ Lumpectomy or wide excision
   - ☐ Mastectomy
   - ☐ Radiation therapy
   - ☐ Chemotherapy
   - ☐ Hormonal therapy (tamoxifen)

3. List date treatment was completed: ____________

4. Is client on any medications? ☐ No ☐ Yes; please give details

5. What stage was the cancer?
   ☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

6. Were lymph nodes involved? ☐ No ☐ Yes; If yes, how many? ______

7. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

8. Date and results of last mammogram: ____________

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

CANCER—CERVICAL

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. Date of diagnoses: ______________________

2. What stage was the cancer?

   ☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

3. How was the cancer treated? (check all that apply)

   ☐ Cone surgery

   ☐ Total hysterectomy

   ☐ Radiation therapy

   ☐ Chemotherapy

4. Indicate date treatment was completed: ______________________

5. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

____

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

____

CANCER—OVARIAN

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. Date of diagnoses: ______________

2. What stage was the cancer?
   ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

3. How was the cancer treated? (check all that apply)
   ☐ Surgery
   ☐ Radiation
   ☐ Chemotherapy

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

5. Please give the date and result of the most recent CA 125 (if available):

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

(Accurate) Name of Medication	Dosage	Reason

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

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CANCER—PROSTATE

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. Date of diagnoses: ______________
2. What was the pretreatment PSA? ______________
3. How was the cancer treated? (check all that apply)
   ☐ Observation only ☐ Radical prostatectomy
   ☐ TURP (transurethral prostatectomy) ☐ Radiation therapy (seed implant or external beam radiation)
4. What is date and result of the most current PSA test?
   ____
   ____
5. What was the Gleason score? ______________
6. What stage was the cancer?
   ☐ Stage 0 (in-situ) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
7. Is there a family history of cancer? ☐ No ☐ Yes
8. What medications is client taking? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

CANCER—SKIN

NAILBA
NAILBA University

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. Date(s) of diagnoses: ______________

2. What was the type of cancer was diagnosed? ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Malignant melanoma

3. Where was the skin cancer located?

4. Has the cancer metastasized (spread) beyond the skin? ☐ No ☐ Yes; please give details

____

____

5. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

____

____

6. For malignant melanoma only, what stage was the cancer?
   ☐ Clark I/in situ ☐ Clark II/Breslow < 0.75mm ☐ Clark III/Breslow .75–1.5mm
   ☐ Clark IV/Breslow 1.51–4.0mm ☐ Clark V/Breslow > 4.0mm

7. What medications is client taking? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

____

CANCER—TESTICULAR

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. Date(s) of diagnoses: ____________
2. What was the type of testicular cancer? ____________
3. Is there a family history of cancer? ☐ No ☐ Yes; please give details

____

____

4. How was the cancer treated? ☐ Surgery ☐ Chemotherapy ☐ Radiation therapy
5. Date treatment was completed: ____________
6. What stage was the cancer? ☐ Stage I ☐ Stage II ☐ Stage III
7. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

____

____

8. Please give the date and result of the most recent AFP or HGC test:

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

CEREBRAL PALSY

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. At what age was it first diagnosed? ______________

2. Is client disabled? ☐ No ☐ Yes; please give details

____

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

____

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CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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 is the type of lung disease? ☐ Chronic bronchitis ☐ Emphysema ☐ Restrictive lung disease ☐ Asthma

2. Date first diagnosed: ______________

3. Has your client ever been hospitalized for this condition? ☐ No ☐ Yes; please give details

____

____

4. Has your client ever smoked?
   - ☐ Yes, and currently smokes ______________ (amount per day)
   - ☐ Yes, smoked in the past but quit ______________ (date quit)
   - ☐ Never smoked

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

(Accurate) Name of Medication	Dosage	Reason

6. Have pulmonary function tests (a breathing test) ever been done? ☐ No ☐ Yes; please give details

____

____

7. Client's build: Height: ________ ' ________ " Weight: ______________

8. Does your client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details

____

____

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

____

____

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CONGESTIVE HEART FAILURE

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. Date of first diagnosis: ______________

2. What is the cause of the CHF? ______________

3. Has the client had surgical heart repair? ☐ No ☐ Yes;

Type ______________ Date: ______________

4. Does client have a history of any of the following? (provide details)
   - ☐ Hypertension ______________
   - ☐ Coronary artery disease ______________
   - ☐ Chronic obstructive pulmonary disease ______________
   - ☐ Pacemaker ______________

5. Has an angiogram, echocardiogram, stress test, or heart scan been done? ☐ No ☐ Yes; please give details and provide a copy if available

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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CORONARY ARTERY DISEASE

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. List date(s) of diagnosis and type of coronary artery disease:

____

____

2. Does client's family have any history of heart disease? ☐ No ☐ Yes; list family member(s) and details

____

____

3. Has client had any of the following?:

- ☐ Heart attack Date: ______ / ______ / ______
- ☐ Coronary angioplasty (PTCA) Date: ______ / ______ / ______
- ☐ Heart failure Date: ______ / ______ / ______
- ☐ Valve surgery Date: ______ / ______ / ______
- ☐ Bypass surger Date: ______ / ______ / ______

4. Has client had any of the following?:

- ☐ Abnormal lipid levels
- ☐ Overweight
- ☐ High blood pressure
- ☐ Irregular heart beats
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Elevated homocysteine
- ☐ Peripheral vascular disease
- ☐ Cerebrovascular or carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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CORONARY ARTERY DISEASE

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. List date(s) of diagnosis and type of coronary artery disease:

____

____

2. Does client’s family have any history of heart disease? ☐ No ☐ Yes; list family member(s) and details

____

____

3. Has client had any of the following?:

- ☐ Heart attack Date: ______ / ______ / ______
- ☐ Coronary angioplasty (PTCA) Date: ______ / ______ / ______
- ☐ Heart failure Date: ______ / ______ / ______
- ☐ Valve surgery Date: ______ / ______ / ______
- ☐ Bypass surger Date: ______ / ______ / ______

4. Has client had any of the following?:

- ☐ Abnormal lipid levels
- ☐ Overweight
- ☐ High blood pressure
- ☐ Irregular heart beats
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Elevated homocysteine
- ☐ Peripheral vascular disease
- ☐ Cerebrovascular or carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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CORONARY BYPASS

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. List date(s) of diagnosis and type of coronary artery disease:

____

2. Does client's family have any history of heart disease? ☐ No ☐ Yes; list family member(s) and details

____

____

3. Has client had any of the following?:

☐ Heart attack Date: ______ /______ /______ ☐ Heart failure Date: ______ /______ /______

☐ Coronary angioplasty (PTCA) Date: ______ /______ /______ ☐ Valve surgery Date: ______ /______ /______

4. Number of vessels by-passed?

5. How badly were the vessels occluded (percentage 0.00%)? ____________

6. Has a follow-up stress (exercise) ECG been completed since procedure?

☐ No ☐ Yes, Normal Date: ______ /______ /______ ☐ Yes, Abnormal Date:______ /______ /______

7. Has client had any chest discomfort since the procedure? ☐ No ☐ Yes; please give details

____

____

8. Has client had any of the following?:

☐ Abnormal lipid levels ☐ Irregular heart beats ☐ Elevated homocysteine ☐ Overweight ☐ Elevated cholesterol

☐ High blood pressure ☐ Diabetes ☐ Peripheral vascular disease ☐ Cerebrovascular or carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

CROHN'S DISEASE

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. Date of first diagnosis: ____________

2. Blood in stools? ☐ No ☐ Yes

3. What type of treatment is client on?

   ☐ Diet

   ☐ Medication—if so, what? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

4. How often does client have attacks?

5. Is condition asymptomatic? ☐ No ☐ Yes

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

____

____

CUSHING SYNDROME

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. List date(s) of diagnosis and type of coronary artery disease:

____

____

2. What evaluation was done? Please give date and results.
   - ☐ MRI, CT Date: ________ / ________ / ________
   - ☐ Blood Test Date: ________ / ________ / ________
   - ☐ Urine Test Date: Date: ________ / ________ / ________

3. Has your client ever been hospitalized for Cushing syndrome? ☐ No ☐ Yes; please give details

____

____

4. Has your client been prescribed steroids for any other illness? ☐ No ☐ Yes; please give details

____

____

5. Is client on any medications now? (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

____

____

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DEMENTIA—ALZHEIMER'S

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. List the type of dementia: ______________________________

2. Date of onset of symptoms: ______ /______ /______ Date of diagnosis: ______ /______ /______

3. Note functional status:
   - ☐ Minimal cognitive changes, fully functioning
   - ☐ Needs supervision outside the home
   - ☐ Assistance needed on any ADL (Activities of Daily Living)
   - ☐ Custodial care

4. Is there also a history of depression? ☐ No ☐ Yes; please give details

____

____

5. Is client on any medications now? (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

____

____

DEPRESSION

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. List the diagnosis: ____

2. Please indicate: Number of episodes ____________________ Date of last episode:____________________

3. Has client been hospitalized for psychiatric treatment? ☐ No ☐ Yes; please give details

____

____

4. Does client have a history of any of the following associated conditions? Please check all that apply. (Additional questionnaires may be required)
   - ☐ Personality disorder
   - ☐ Psychotic disorder
   - ☐ Suicidal thought/attempt
   - ☐ Substance abuse (alcohol or drugs) (complete questionnaire)
   - ☐ Other psychiatric disorder

5. Is the client currently working? ☐ No ☐ Yes; please list occupation

____

____

6. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

DIABETES

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. Date first diagnosed: ________ /________ /________

2. How often does your client visit his/her physician?

   When was the last visit? ________ / ________ /________

3. The client's diabetes is controlled by:
   - ☐ Diet alone
   - ☐ Oral medication (medication and doses)______________________
   - ☐ Insulin (amount and units/day) ______________________

4. Please give the most recent blood sugar reading:______________________

5. Does client monitor his/her own blood sugar?______________________

6. If available, please give the most recent glycohemoglobin (BhA1C) or fructosamine level: ______________________

7. Please check if your client has (had) any of the following:

   ☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated lipids
   ☐ Overweight ☐ Neuropathy ☐ Kidney disease
   ☐ Retinopathy ☐ Abnormal ECG ☐ Hypertension

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

DOWN SYNDROME / INTELLECTUAL DISABILITY

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 is applicant's IQ? ______________

2. Is there also a history of depression? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

DOWN SYNDROME

1. What is applicant's social and economic situation?

____

____

2. Are there any cardiovascular or pulmonary problems? ☐ No ☐ Yes; please give details

____

____

INTELLECTUAL DISABILITY

1. At what age was the applicant diagnosed? ______________

2. Is the disability chromosomal? ☐ No ☐ Yes; please provide as much detail as possible

____

____

____

____

____

DRIVING

NAILBA
NAILBA University

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. In the past 5 years, has client’s drivers license been suspended or revoked? ☐ No ☐ Yes; please give details

____

____

2. In the past 5 years, has client been convicted of, or pled guilty or no contest to, reckless driving or driving under the influence of alcohol or drugs?

☐ No ☐ Yes; please give details

____

____

3. What is applicant’s occupation? ______________________________

4. Is applicant married? ☐ No ☐ Yes

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DRUGS

NAILBA
NAILBA University

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. Date of the initial treatment or diagnosis? ______________

2. What is client’s: ☐ Martial status: ______________ ☐ Occupation: ______________
   ☐ Length of employment: ______________

3. Is client an active member of a drug use recovery group? ☐ No ☐ Yes; how long?______________

4. Has client ever joined and then left a drug use recovery group? ☐ No ☐ Yes; please give details

5. What drug(s) were used or abused? (name of drug and dates of usage)

6. Were there any relapses from sobriety/abstinence? ☐ No ☐ Yes; please list dates

7. Has client ever been convicted of any drug-related activity? ☐ No ☐ Yes; please give details

8. Have there been physical complications or additional psychiatric problems? ☐ No ☐ Yes; please give details

9. What is client’s current level of alcohol consumption? ______________

10. Is client taking 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

EATING DISORDERS

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. 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

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

____

____

EMPHYSEMA

NAILBA
NAILBA University

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 is the cause? ☐ Asthma ☐ Occupation ☐ Smoking
2. What is the degree of severity? ____________
3. Does client use oxygen? ☐ No ☐ Yes
4. Has client ever been hospitalized? ☐ No ☐ Yes; please give details

____

____

5. Have pulmonary function tests been done? ☐ No ☐ Yes; what were the results?

____

____

6. Are there any restrictions of activities? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

ENLARGED HEART

NAILBA
NAILBA University

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. 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

____

____

EPILEPSY

NAILBA
NAILBA University

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. Date of first diagnosis: ______________________

2. Indicate the type of seizure:

   ☐ Complex/partial seizure ☐ Tonic-clonic seizure ☐ Absense seizure ☐ Myoclonic seizure

3. Indicate the number or frequency of episodes and date of last episode:

____

____

4. Has client been hospitalized for treatment of epilepsy? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

6. What is client's occupation? ______________________

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

____

____

GLOMERULONEPHRITIS

NAILBA
NAILBA University

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. Please note type of Glomerulonephritis: ______________________
2. Please list date of first diagnosis: ______________________
3. Was a kidney biopsy done? ☐ No ☐ Yes; please give date and diagnosis

____

____

4. Please provide the client's most recent readings for:
   - ☐ Blood pressure ______________________
   - ☐ BUN ______________________
   - ☐ Creatinine ______________________
   - ☐ Urinalysis ______________________
5. Is client on any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

HEART ATTACK—MYOCARDIAL INFARCTION

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. List date(s) of the heart attack(s): ____________

2. Has the client had any of the following:
   - ☐ Echocardiogram Date: ____________
   - ☐ Coronary catheterization Date: ____________
   - ☐ Coronary angioplasty Date: ____________
   - ☐ Bypass surgery Date: ____________
   - ☐ Heart failure Date: ____________
   - ☐ Arrhythmias Date: ____________

3. Has a follow-up stress (exercise) ECG been completed since the heart attack? ☐ No ☐ Yes; please give details

____

____

4. Please check if your client has had any of the following:
   - ☐ Abnormal lipid levels
   - ☐ Irregular heartbeats*
   - ☐ Peripheral vascular disease*
   - ☐ Overweight
   - ☐ Diabetes; age of onset: ____________
   - ☐ Cerebrovascular or carotid disease
   - ☐ High blood pressure
   - ☐ Elevated homocysteine

**These conditions require an additional questionnaire to be completed, please request.*

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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HEART FAILURE

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 was the cause of heart failure? ______________________________

2. When was the diagnosis made? ______________________________

3. Has client had surgical heart repair? ☐ No ☐ Yes; please give date and diagnosis

____

____

4. Does client have a history of any of the following (please provide details or complete the questionnaire for the condition):
   - ☐ Hypertension ______________________________
   - ☐ Coronary artery disease ______________________________
   - ☐ Chronic obstructive pulmonary disease ______________________________
   - ☐ Pacemaker ______________________________

5. Has client had surgical heart repair? ☐ No ☐ Yes; please give date and diagnosis

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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HEART MURMUR

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 murmur does client have?

   ☐ Aortic stenosis ☐ Aortic regurgitation ☐ Aortic insufficiency
   ☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral insufficiency
   ☐ Pulmonic stenosis ☐ Flow murmur ☐ Innocent murmur

2. When was the heart murmur first discovered? ____________

3. Does client have a history of rheumatic fever? ☐ No ☐ Yes

4. When was the client last seen by a physician for the heart murmur? ____________

5. When was the last echocardiogram done? ____________

   What were the results? ____________

6. Was a cardiac catheterization ever done? ☐ No ☐ Yes; please give date ____________

7. Does client have any symptoms or any limitation of activities? ☐ No ☐ Yes; please give details

8. Has client had any heart surgery or has surgery been discussed? ☐ No ☐ Yes; please give details

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

(Accurate) Name of Medication	Dosage	Reason

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

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HEMOCHROMATOSIS

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. Date of first diagnosis: ____________

2. What organs are involved? (check all that apply)
   - ☐ Liver
   - ☐ Pancreas (diabetes)
   - ☐ Joints
   - ☐ Heart
   - ☐ Pituitary

3. When was the last phlebotomy treatment? ____________

4. Was a liver biopsy done? ☐ No ☐ Yes; please provide a copy

5. If available, please provide the most recent serum ferritin result: ____________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

HEPATITIS

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. Date of first diagnosis: ______________________

2. What type of hepatitis: ☐ A ☐ B ☐ C

3. Was the hepatitis due to:

   ☐ Hepatitis A ☐ Hepatitis C (non-A/non-B ☐ Hepatitis B, resolved ☐ Hepatitis B, carrier or chronic infection

   ☐ Other, please specify ______________________

4. Please give the date and results of the most recent liver enzyme tests:

   ☐ AST/SGOT Date:______________ ☐ ALT/SGPT Date:______________ ☐ GGTP Date:______________

   Result:______________ Result:______________ Result:______________

5. Does the client drink alcohol? ☐ No ☐ Yes; please give details ______________________

6. Please check if any of the following studies have been completed:

   ☐ Liver ultrasound or CT scan ☐ normal ☐ abnormal

   ☐ Liver biopsy ☐ normal ☐ abnormal

   ☐ No further evaluation

7. Has client been diagnosed with any of the following: ☐ Chronic hepatitis ☐ Cirrhosis

8. Was there any treatment done? ☐ No ☐ Yes; what type?______________________

9. When did treatment start ______________________and terminate ______________________

10. Was treatment successful in eliminating the virus? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

HYPERCOAGULABLE DISORDER

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. Date of diagnosis: ______________________

2. Please note type of treatment:
   - ☐ Hospitalization Date: ______________________
   - ☐ Coumadin
   - ☐ Aspirin
   - ☐ Heparin

3. Was there a thromboembolic event?
   ☐ MI ☐ CVA ☐ DVT ☐ DVT ☐ Other ☐ None

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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HYPERGLYCEMIA

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. Date of diagnosis: ______________

2. What were the last 4 levels for:
   - ☐ Glycohemoglobin: ______________
   - ☐ Glucose: ______________
   - ☐ Microalbumin: ______________

3. Is condition controlled? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

HYPERTENSION

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. Date of diagnosis: ______________________________

2. What was the most recent blood pressure reading? ______________________

3. Please check any of the below that client has had:
   - ☐ Chest pain or coronary artery disease
   - ☐ Diabetes
   - ☐ Family history of: heart disease, high blood pressure, stroke
   - ☐ Abnormal lipid levels
   - ☐ TIA or stroke
   - ☐ Enlarged heart
   - ☐ Aneurysm
   - ☐ Peripheral vascular disease
   - ☐ Kidney disease
   - ☐ Overweight

4. Has a stress electrocardiogram (treadmill test) been completed within the past year?
   ☐ No ☐ Yes; normal Date:__________________ ☐ Yes; abnormal Date: __________________

5. Has client ever had an echocardiogram? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

IRREGULAR HEARTBEAT

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. Date first diagnosed: ______________________

2. Is the irregular heatbeat due to (check all that apply):
   - ☐ Premature supraventricular atrial beats (PACs)
   - ☐ Premature ventricular beats (PVCs
   - ☐ Multifocal
   - ☐ Bigeminy or trigeminy
   - ☐ Ventricular tachycardia

3. Are there any symptoms with the irregular heartbeat?
   ☐ Black-out ☐ Dizziness (lightheadedness)/faint feeling ☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? (If so, please give date and results)
   - ☐ ECG Date: ______________ ______________
   - ☐ Stress Date: ______________ ______________
   - ☐ Echocardiogram Date: ______________ ______________
   - ☐ Holter monitor Date: ______________ ______________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

KIDNEY FUNCTION TESTS

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. Date first diagnosed: ______________________________

2. Please check if any of these conditions are present (complete questionnaire for each condition checked):
   - ☐ Diabetes
   - ☐ Polycystic kidney disease
   - ☐ Glomerulonephritis
   - ☐ Nephrosclerosis
   - ☐ Systemic lupus erythematosus
   - ☐ Other: ______________________________

3. Give most recent results of kidney function tests:
   - ☐ BUN ______________________________
   - ☐ Serum creatinine ______________________________
   - ☐ Urinalysis ______________________________

4. Have any of the following occurred (check all that apply):
   - ☐ Frequent infection
   - ☐ High blood pressure
   - ☐ Cardiovascular disease (complete questionnaire for this condition)

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

KIDNEY TRANSPLANT

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. Date of the transplant: ____________

2. ☐ Single or ☐ multiple transplant?

3. What was the cause of the end stage renal disease which led to the transplant? (Cause for the transplant)
   ☐ Diabetes ☐ Glomerulonephritis ☐ Nephrosclerosis ☐ Systemic lupus erythematosus
   ☐ Polycystic kidney disease ☐ Other:____________

4. What was the source of the donor kidney?
   ☐ Cadaver ☐ Living related donor ☐ Identical twin ☐ Other:____________

5. Please give most recent results of kidney function tests:
   ☐ BUN____________
   ☐ Serum creatinine____________
   ☐ Urinalysis ____________

6. Have any of the following occurred (check all that apply):
   ☐ Frequent infection ☐ Rejection episodes ☐ Toxicity from treatment ☐ High blood pressure
   ☐ Polycystic kidney disease ☐ Cancer ☐ Disease recurrence

7. How often are checkups? ____________

8. Are there any disabilities since the transplant? ☐ No ☐ Yes; please give details
   ____

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

(Accurate) Name of Medication	Dosage	Reason

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

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LEUKEMIA

NAILBA
NAILBA University

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. Date of diagnoses: ______________________________

2. What is the current stage of the leukemia?
   - ☐ Stage 0
   - ☐ Stage I
   - ☐ Stage II
   - ☐ Stage III
   - ☐ Stage IV

3. Please provide results of the most recent CBC (complete blood count):
   - ☐ Date ______________________________
   - ☐ Hemoglobin ______________________________
   - ☐ White blood cell count ______________________________
   - ☐ Platelet count ______________________________

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

____

____

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LIVER TESTS

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. Date of diagnoses: ______________

2. How long has this abnormality (elevated liver enzymes) been present?

3. Please give the date and results of the most recent liver enzyme tests.
   a) AST/SGOT Date: ______________ ______________
   b) ALT/SGPT Date: ______________ ______________
   c) GGTP Date: ______________ ______________
   d) ALP Date: ______________ ______________
   e) Billirubin Date: ______________ ______________

4. Have these results been :
   ☐ Increasing
   ☐ Decreasing
   ☐ Fluctuating up and down
   ☐ Stable
   ☐ Unknown

5. Does client drink alcohol? (answer all that apply)
   ☐ No ☐ Yes; please note amount and frequency ______________
   ☐ Drinking pattern changed recently ______________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

LUNG DISEASE

NAILBA
NAILBA University

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. Date of diagnoses: ______________

2. Type of lung disease:
   ☐ Interstitial lung disease; type ______________
   ☐ Chronic bronchitis ☐ Emphysema ☐ Asthma

3. Was a biopsy done? ☐ No ☐ Yes

4. Has client improved since diagnosis? ☐ No ☐ Yes

5. Has client ever been hospitalized for this condition? ☐ No ☐ Yes

____

____

6. Has client ever smoked?
   ☐ Yes; currently smokes______________(amount/day)
   ☐ Yes; smoked in the past but quit ______________(date)
   ☐ Never smoked

7. Have pulmonary function tests (breathing test) ever been done? ☐ No ☐ Yes; please give most recent test results

____

____

8. Does client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

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LUPUS

NAILBA
NAILBA University

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. Date of diagnoses: ____________________

2. Type of lupus diagnosed?

   ☐ Systemic lupus erythematosus (SLE) ☐ Discord lupus ☐ Drug-induced SLE

3. Please note if the lupus is:

   ☐ in remission (list date of last exacerbation) Date: ____________

   ☐ currently present

4. Check if client has had any of the following:

   ☐ Low blood counts ☐ Neurologic disorder

   ☐ Lung involvement (pleuritis) ☐ Heart involvement (pericarditis)

   ☐ Proteinuria ☐ Renal insufficiency or failure

   ☐ High blood pressure

5. What type of treatment has client had? ____________________

6. When was treatment terminated? ____________________

7. Have steroids ever been prescribed? ☐ No ☐ Yes; please give details

____

____

8. Is client presently on medication? (accurate name, dosage, and reason) ☐ No ☐ Yes; please give details

(Accurate) Name of Medication	Dosage	Reason

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

____

____

LYMPHOMA

NAILBA
NAILBA University

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. Date of diagnoses: ______________________________

2. Indicate the type of lymphoma:
   - ☐ Hodgkin's Lymphoma __Non-Hodgkin's Lymphoma—low grade
   - ☐ Non-Hodgkin's Lymphoma—intermediate-grade
   - ☐ Non-Hodgkin's Lymphoma—high grade

3. What was the staging at the time of diagnosis?
   ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

4. Please note if any of the following were present at time of diagnosis (check all that apply):
   - ☐ Type B symptoms (fever, weight loss, and/or night sweats)
   - ☐ Large mediastinal (chest) disease (tumor > 7.5 cm)
   - ☐ Elevated LDH (blood test)
   - ☐ More than 1 extranodal site involved

5. What treatment did client receive? (check all that apply)
   ☐ Chemotherapy ☐ Radiation ☐ Surgery
   What was the date of the last treatment? ______________________________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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MENTAL DISORDERS

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

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. Describe client’s condition. Give the diagnosis.

____

____

2. Date of first symptoms? ____________________

3. When did client last see doctor for this condition? ____________________

4. Has client been hospitalized? ☐ No ☐ Yes; (list all)

Date ____________ ____________________

Date ____________ ____________________

5. Is client currently employed? ☐ No ☐ Yes

6. Has condition interfered with work? ☐ No ☐ Yes; If so, how long?____________________

7. Is client disabled? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

9. When was the last medication adjustment made?

Details ____

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

____

____

MITRAL VALVE DISORDER

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. How long has this abnormality been present? ______________________

2. Please check the type(s) of valve disorder present:
   ☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral valve prolapse

3. Have any of the following occurred?
   ☐ Chest pain ☐ No ☐ Yes
   ☐ Trouble breathing ☐ No ☐ Yes
   ☐ Heart failure ☐ No ☐ Yes
   ☐ Palpitations ☐ No ☐ Yes
   ☐ Atrial fibrillation/flutter ☐ No ☐ Yes

4. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease, etc.)?
   ☐ No ☐ Yes; please give details

____

____

5. Have additional studies been completed? (check all that apply)
   ☐ Echocardiogram Date: ______________________
   ☐ Cardiac catheterization Date: ______________________
   ☐ None

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

MITRAL VALVE PROLAPSE

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. How long has this abnormality been present? ______________________________

2. Have any of the following symptoms occurred? (check all that apply)
   - ☐ Fainting or dizziness ☐ No ☐ Yes
   - ☐ Palpitations ☐ No ☐ Yes
   - ☐ Shortness of breath ☐ No ☐ Yes
   - ☐ Chest pain ☐ No ☐ Yes

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?
   ☐ No ☐ Yes; please submit a copy of the report

   ____

   ____

4. Has an echocardiogram (ultrasound of the heart) been done? ☐ No ☐ Yes; please submit a copy of the report

   ____

   ____

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

(Accurate) Name of Medication	Dosage	Reason

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

   ____

   ____

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MULTIPLE SCLEROSIS

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. List date of first diagnosis: ____________________

2. Indicate number of episodes: ____________________

3. Date of last episode: ____________________

4. Please note current neurological status and/or symptoms.
   - ☐ Normal
   - ☐ Minimal residual impairment (please specify) ____________________
   - ☐ Moderate residual impairment (please specify) ____________________
   - ☐ Severe residual impairment (please specify) ____________________

5. What are client’s current symptoms?

____

____

6. What therapy is client on?

____

____

7. Does client have any problems with extremities, kidneys, or bladder? ☐ No ☐ Yes; please give details

____

____

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

NEUROMUSCULAR DISORDER

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. List date of first diagnosis: ____________
2. Name of neuromuscular disorder: ____________
3. Describe condition with diagnosis: ____________
4. What is your condition? ____________
5. Is client disabled? ☐ No ☐ Yes
6. Does client use a cane or a wheelchair? ☐ No ☐ Yes
7. Does client have a caregiver? ☐ No ☐ Yes
8. Is client receiving any treatment? ☐ No ☐ Yes; what type? ____________
9. When did client last see doctor for this condition? ____________
10. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

PACEMAKER

NAILBA
NAILBA University

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. Date the pacemaker was implanted: ______________________

2. The pacemaker was implanted for:
   - ☐ Heart block associated with coronary artery disease
   - ☐ Complete heart block or sick sinus syndrome
   - ☐ Chronic underlying atrial flutter/fibrillation
   - ☐ Other; give details______________________

3. Does client have another heart disease? Give details:

____

____

4. Have any of the following pacemaker complications occurred?
   ☐ Infection ☐ Blood clots ☐ Pacemaker malfunction ☐ Perforation
   ☐ Other; please give details______________________

5. Are there any continuing symptoms since the pacemaker was implanted? ☐ No ☐ Yes; please give details

____

____

6. When was client's last checkup? ______________________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

PANCREATITIS

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. List the date when first diagnosed: ____________

2. What type of pancreatic disorder was diagnosed?
   ☐ Cyst, Pseudocyst ☐ Abscess ☐ Pancreatitis ☐ Stone
   ☐ Other; give details____________

3. Was client incapacitated from work due to the pancreatic disorder? ☐ No ☐ Yes; please give details

4. Was client hospitalized? ☐ No ☐ Yes; (give dates and how long below)
   Date:____________ Duration ____________
   Date:____________ Duration ____________
   Date:____________ Duration ____________

5. Was any surgery performed? ☐ No ☐ Yes; please give details

6. If pancreatitis, describe frequency of attacks and date of most recent attack:

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

(Accurate) Name of Medication	Dosage	Reason

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

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PANHYPOPITUITARISM

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. When was client diagnosed with pituitary dysfunction? ______________________

2. What was the cause of the pituitary dysfunction?

____

____

3. What kind of hormone replacement therapy is required?

____

____

4. Please list dates of any hospitalizations, radiation treatments, or surgeries.
   If there was a tumor, please provide a pathology report and the results of any scans.

   Date: ______________ ______________________

   Date: ______________ ______________________

   Date: ______________ ______________________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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PARALYSIS—SIMILAR PHYSICAL DISABILITY

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. Date disability occured? ______________________

2. What was the cause (e.g., congenital, injury, polio)?

____

____

3. What parts of the body are affected?

____

____

4. Does client have limitations in walking, driving, speech or other activities? ☐ No ☐ Yes

5. Has surgery been performed or planned? ☐ No ☐ Yes

6. Has client's bowel or bladder function been affected? ☐ No ☐ Yes

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

____

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PARKINSON'S DISEASE

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. Date of first diagnosed: ______________________________

2. Please note the functional stage of the client currently:
   - ☐ Stage I unilateral involvement
   - ☐ Stage II bilateral involvement but normal stance
   - ☐ Stage III bilateral involvement with mild postural imbalance, but able to lead an independent life
   - ☐ Stage IV bilateral involvement with postural instability; requires substantial help
   - ☐ Stage V severe disease; restricted to bed or wheelchair

3. Has there been any evidence of progression? ☐ No ☐ Yes; please give details

____

____

4. Please note if any of the following have occurred (check all that apply):

☐ Dementia	☐ Recurrent infections
☐ Memory problems	☐ Falls
☐ Aspiration	☐ Recurrent injuries
☐ Pneumonia	☐ Depression

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

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PERSONALITY DISORDERS

NAILBA
NAILBA University

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. Date of diagnosis? ______________________

2. Please note which type of personality disorder has been diagnosed:

☐ Antisocial ☐ Narcissistic
☐ Borderline ☐ Histrionic
☐ Paranoid ☐ Dependent
☐ Schizoid ☐ Obsessive/Compulsive
☐ Schizotypical ☐ Avoidant

3. Has client been hospitalized for a psychiatric illness? ☐ No ☐ Yes; please give dates and details

____

____

4. Does your client have any of the following associated conditions?

Substance abuse (alcohol or drugs): ☐ No ☐ Yes; please give details ______________
Mood disorder (e.g., depression): ☐ No ☐ Yes; please give details ______________
Suicidal thought/attempt: ☐ No ☐ Yes; please give details ______________
Other psychiatric disorder: ☐ No ☐ Yes; please give details ______________

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

(Accurate) Name of Medication	Dosage	Reason

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

____

____

PHEOCHROMOCYTOMA

NAILBA
NAILBA University

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. 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 dates and 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

____

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POLYCYSTIC KIDNEY DISEASE

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. Do any other family members have ADPKD? ☐ No ☐ Yes; please give details

____

____

2. Was ADPKD diagnosed by ultrasound? ☐ No ☐ Yes
3. What are your current blood pressure readings? ☐ No ☐ Yes
4. Please provide the results and date of your most recent urinalysis.
   Protein ____________ Date: ____________
   Red blood cell (RBC) ____________ Date: ____________
   White blood cell (WBC) ____________ Date: ____________
   Protein/creatinine ratio ____________ Date: ____________
5. Please provide the date and results of the most recent kidney function tests.
   BUN ____________ Date: ____________
   Serum Creatinine ____________ Date: ____________
6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

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POLYP, CYST, TUMOR, OR GROWTH

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 growth did client have? ____________________

2. When was it discovered? Date: ____________________

3. What is the specific location in or on the body where it is located?

____

____

4. How many were present or removed? ____________________

5. What type of treatment has client had? ____________________

6. If removed surgically, what was the pathological diagnosis? ☐ Benign ☐ Malignant
   If you have pathology report available, please provide it.

7. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

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PROSTATE BENIGN

(BENIGN PROSTATIC HYPERTROPHY AND PROSTATITIS)

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. Date when first diagnosed: ______________________________

2. If any of the following have been done, please give details and result(s):
   - ☐ Bladder catheterization ______________________________
   - ☐ Prostate biopsy______________________________
   - ☐ Prostate ultrasound ______________________________
   - ☐ TURP (transurethral prostatectomy)______________________________

3. Please give result and date of most recent PSA test:

   Date: ________________ ______________________________

4. Is client taking any medication? (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

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PROTEINURIA (PROTEIN IN URINE)

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. How long has this abnormality been present? ______________ years

2. Has a specific cause for the proteinuria been found? ☐ No ☐ Yes; please give details

____

____

3. Give the date and results of the most recent urinalysis:
   - a. Protein ______________ Date: ______________
   - b. Red blood cells (RBCs) ______________ Date: ______________
   - c. White blood cell (WBC) ______________ Date: ______________
   - d. Protein/creatinine ratio ______________ Date: ______________

4. Give the dates and results of the most recent kidney function tests:
   - BUN ______________ Date: ______________
   - Serum Creatinine ______________ Date: ______________

5. If any of the following urinary tests have been completed, give the date and result:
   - a. Microalbumin ______________ Date: ______________
   - b. 24-hr. protein ______________ Date: ______________
   - c. 24-hr. creatinine clearance ______________ Date: ______________
   - d. Other: ______________ Date: ______________

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

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PSA—ELEVATED

NAILBA
NAILBA University

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. How long has the PSA been elevated? ____________

2. What is the diagnosis? ____________

3. Please give the date and result(s) of all recorded PSA value(s):

____

____

4. Have these results been:
   - ☐ Increasing
   - ☐ Decreasing
   - ☐ Stable
   - ☐ Fluctuating up and down
   - ☐ Unknown

5. If any of the following have been done, please give the details and result(s):
   - ☐ TRUS ____________
   - ☐ PSAD ____________
   - ☐ Free PSA ____________
   - ☐ Prostate biopsy ____________

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

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SARCOIDOSIS

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. Date of first diagnosis: ______________________

2. Was a biopsy done? ☐ No ☐ Yes

3. Stage: ______________________

4. How was the sarcoid treated? ☐ No treatment ☐ Prednisone

5. Date treatment was completed: ______________________

6. What organs were involved? (check all that apply)
   ☐ Lung ☐ Kidney ☐ Heart ☐ Central nervous system
   ☐ Liver or spleen ☐ Skin ☐ Eyes ☐ Lymph nodes

7. Give results of the most recent pulmonary function tests:
   FVC ______________________
   FEV1 ______________________

8. Has there been any evidence of recurrence/progression? ☐ No ☐ Yes; please give details
____
____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

SCLERODERMA / CREST

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. Please note type of scleroderma:
   - ☐ Localized scleroderma-morphea or linea
   - ☐ Limited scleroderma/CREST
   - ☐ Progressive systemic sclerosis-diffuse scleroderma
2. Please list date of first diagnosis: ______________________
3. Please check if client has had any of the following:
   - ☐ Weight loss
   - ☐ Heart disease
   - ☐ Lung disease
   - ☐ Reyaud’s disease
   - ☐ Biliary cirrhosis
   - ☐ Liver enzyme abnormality
   - ☐ Kidney disease
   - ☐ Trouble swallowing
4. Please list functional ability:
   - ☐ Fully active
   - ☐ Sedentary
   - ☐ Uses walker, cane, etc.
   - ☐ Uses wheelchair
5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

SEIZURE DISORDER (EPILEPSY)

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. Date of first diagnosis: ______________

2. When did client have the first and last attack? ______________

3. Are the attacks ☐ grand mal or ☐ petit mal in character?

4. What is the frequency of the attacks?

5. What type of treatment is indicated?

6. When did client last see his/her physician for this condition?

7. What is client’s occupation? ______________

8. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

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SICKLE CELL ANEMIA

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. Date of diagnosis: ______________________

2. What type of sickle cell anemia does client have?
   - ☐ Sickle cell (SS)
   - ☐ Sickle cell (SC)
   - ☐ Sickle cell trait (SA)
   - ☐ Hemoglobin C

3. Is there a history of complications? ☐ No ☐ Yes; please check those that apply and give the date of the last episode.
   - ☐ Painful crisis Date: ______________
   - ☐ Aaseptic necrosis of bones Date: ______________
   - ☐ Leg ulcers Date: ______________
   - ☐ Lung scarring Date: ______________
   - ☐ Thrombosis Date: ______________
   - ☐ Enlarged heart Date: ______________
   - ☐ Other: ______________ Date: ______________

4. What is the current hemoglobin? ______________________

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

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SLEEP APNEA

NAILBA
NAILBA University

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. Date of diagnosis: ______________________

2. Was the sleep apnea diagnosed as:
   ☐ Obstructive ☐ Central ☐ Mixed ☐ Unknown

3. How is the sleep apnea being treated?
   ☐ Observation alone
   ☐ Weight loss
   ☐ CPAP mask; if CPAP given, date use was terminated:______________________
   ☐ Surgery; Date of surgery: ______________________
   ☐ Other; please give details______________________

4. If surgery was done, was sleep apnea corrected? ☐ No ☐ Yes; please give details

____

____

5. Has client had any of the following?
   ☐ Lung disease ☐ Overweight ☐ Chest pain or coronary artery disease
   ☐ Depression ☐ Stroke ☐ Arrhythmia

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

SPINAL CORD INJURY (PLEGIC)

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. Date of diagnosis: ______________________

2. At what spinal cord level was the injury? (list specific vertebrae, if available)
   - ☐ Cervical spine ______________________
   - ☐ Thoracic spine ______________________
   - ☐ Lumbrosacral spine ______________________

3. Note current level of function:
   - ☐ Incomplete paraplegia ☐ Complete paraplegia
   - ☐ Incomplete quadriplegia ☐ Complete quadriplegia

4. Have any of the following occurred? (check all that apply)
   - ☐ Pneumonia
   - ☐ Skin ulcers
   - ☐ Urinary tract infection
   - ☐ Kidney impairment
   - ☐ Depression

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

STENT

NAILBA
NAILBA University

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. When and where was the stent put in? ______________________________

2. What type of stent was put in? ______________________________

3. Why was the stent put in?

____

4. How many vessels were involved? ______________________________

5. Has the applicant had an imaged stress test done? ☐ No ☐ Yes; if yes, when and what were the results?

____

____

6. What type of follow-up testing has been done and what were the results?

____

7. Was there a heart attack prior to the stent being put in? ☐ No ☐ Yes

8. Is there family history of heart disease? ☐ No ☐ Yes; please give details

____

____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

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STROKE, TIA

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. Date(s) of the episode(s)? ______________

2. Were any of the following studies completed?
   - ☐ Carotid ultrasound Date: ______________
   - ☐ Head CT scan or MRI scan Date: ______________
   - ☐ Echocardiogram Date: ______________

3. Was client hospitalized? ☐ No ☐ Yes; please give details

____

4. When did client last see their doctor for evaluation? ______________

5. Please check any of the of the following that your client has had:
   - ☐ Elevated cholesterol ☐ Stroke ☐ Diabetes ☐ Heart attack
   - ☐ High blood pressure ☐ Peripheral vascular disease ☐ Coronary artery disease

6. Has surgery ever been done on any carotid artery(ies)? ☐ No ☐ Yes; please give details

____

7. Give the date and result of the most recent blood pressure readings: ______________

8. Are there any residuals (limitation of movement, speech, or vision)? ☐ No ☐ Yes; please give details

____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

____

THROMBUS (HYPERCOAGULABLE CLOTTING DISORDER)

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. Date of diagnosis: ______________________

2. Note the type of treatment:
   - ☐ Coumadin
   - ☐ Aspirin
   - ☐ Heparin
   - ☐ Hospitalization Date:______________________

3. Was there a Thromboembolic event?
   - ☐ MI
   - ☐ DVT
   - ☐ CVA
   - ☐ PE
   - ☐ Other ______________________
   - ☐ None

4. Has there been any evidence of recurrence? ☐ No ☐ Yes; please give details

____

____

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

____

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THYROID DISEASE

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. Date of diagnosis: ______________

2. Was the thyroid disease diagnosed as (more than one is possible)?
   - ☐ Goiter
   - ☐ Thyroid nodule
   - ☐ Hyperthyroidism
   - ☐ Hypothyroidism

3. How is the thyroid disease being treated?
   - ☐ Surgery
   - ☐ Radioactive iodine
   - ☐ Medication

Please give details: ______________

4. Has a biopsy or fine needle aspiration (FNA) been done? ☐ No ☐ Yes; please provide a copy of the report.

5. Has client had an ultrasound or radioactive scan of the thyroid? ☐ No ☐ Yes; please provide a copy of the report.

6. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

T WAVE CHANGES

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. How long has this abnormality been present? ____________________

2. Has there been any recent change in the ECG (last 12 month)? ☐ No ☐ Yes; please give details

____

____

3. Please check if your client has had any of the following: (check all that apply)

   a) Chest pain, coronary artery disease, or other cardiovascular impairment ☐ No ☐ Yes; please give details

   ____

   ____

   b) Diabetes ☐ No ☐ Yes

   c) Elevated cholesterol ☐ No ☐ Yes

   d) High blood pressure ☐ No ☐ Yes

4. Have any other studies been completed?

   a) Exercise treadmill or thallium: ☐ No ☐ Yes, normal ☐ Yes, abnormal

   b) Resting or exercise echocardiogram: ☐ No ☐ Yes, normal ☐ Yes, abnormal

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

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