

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

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

ARTHRITIS

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?

- Date of first diagnosis: _____
- Is the atrial fibrillation/flutter: Chronic (permanent) Proxysmal (intermittent)
- Are there any symptoms with the irregular heart beat?
 - Black-out Dizziness (light-headedness)/faint feeling
 - Palpitations Chest discomfort
- 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

- The cause of the atrial fibrillation/flutter is due to:
 - Coronary heart disease Alcohol
 - Thyroid disease Cardiomyopathy
 - Mitral valve disease Unknown
 - Other, give details _____
- Are there any other health issues? (additional questionnaires may be required) No Yes; please give details

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:

CLIENT NAME: _____ **Date:** _____
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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

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



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

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

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

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

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
- _____
- _____

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

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

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

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



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

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



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: _____ / _____ / _____

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

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?

- List the diagnosis: _____
- Please indicate: Number of episodes _____ Date of last episode: _____
- Has client been hospitalized for psychiatric treatment? No Yes; please give details

- 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:

<input type="checkbox"/> Chest pain or coronary artery disease	<input type="checkbox"/> Protein in the urine	<input type="checkbox"/> Elevated lipids
<input type="checkbox"/> Overweight	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Abnormal ECG	<input type="checkbox"/> 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



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

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: Marital 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.)

- | | |
|---|---|
| <input type="checkbox"/> Substance abuse (alcohol or drugs) | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> Psychotic disorder | <input type="checkbox"/> Suicidal thought/attempt |
| <input type="checkbox"/> Depression | <input type="checkbox"/> 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

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



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?

- When was the condition first diagnosed? _____
- Have any of the following symptoms occurred?
 - Chest discomfort
 - Fainting spells or dizziness
 - Shortness of breath
 - Palpitations (irregular heart beat)
- Please check if your client has had any of the following:

Chest X-ray	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Normal	<input type="checkbox"/> Yes, Abnormal
Exercise treadmill or thallium	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Normal	<input type="checkbox"/> Yes, Abnormal
Resting or exercise echocardiogram	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Normal	<input type="checkbox"/> Yes, Abnormal
MUGA	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Normal	<input type="checkbox"/> Yes, Abnormal
Cardiac catheterization	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Normal	<input type="checkbox"/> Yes, Abnormal
- 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

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



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?

- Date of first diagnosis: _____
- Indicate the type of seizure:
 Complex/partial seizure
 Tonic-clonic seizure
 Absence seizure
 Myoclonic seizure
- 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

- What is client's occupation? _____
- Does client have any other major health issues? (additional questionnaires may be required) No Yes; please give details

GLOMERULONEPHRITIS



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

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



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

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



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 heartbeat 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?

- Date first diagnosed: _____
- 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: _____

- Give most recent results of kidney function tests:
 - BUN _____
 - Serum creatinine _____
 - Urinalysis _____

- 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



LEUKEMIA



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

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



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

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) Discoid 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



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

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?

- How long has this abnormality been present? _____
- Please check the type(s) of valve disorder present:
 Mitral stenosis Mitral regurgitation Mitral valve prolapse
- 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
- 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

- 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

- 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

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

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

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



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 occurred? _____
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

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

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

- Antisocial Narcissistic
- Borderline Histrionic
- Paranoid Dependent
- Schizoid Obsessive/Compulsive
- Schizotypal 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



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?

- Date of diagnosis? _____
 Benign vs. Malignant
 Single vs. Multiple
- What evaluation was done? Please give date and results.
 MRI, CT Date: _____
 Urine Test Date: _____
 Blood Test Date: _____
- 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

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

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

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

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?

- Date when first diagnosed: _____
- If any of the following have been done, please give details and result(s):
 - Bladder catheterization _____
 - Prostate biopsy _____
 - Prostate ultrasound _____
 - TURP (transurethral prostatectomy) _____
- 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

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
- _____
- _____

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

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 Biliary cirrhosis
 - Heart disease Liver enzyme abnormality
 - Lung disease Kidney disease
 - Reynaud's 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

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?

- Date of diagnosis: _____
- 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: _____
 - Aseptic 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

SLEEP APNEA



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?

- Date of diagnosis: _____
- At what spinal cord level was the injury? (list specific vertebrae, if available)
 - Cervical spine _____
 - Thoracic spine _____
 - Lumbrosacral spine _____

- Note current level of function:
 - Incomplete paraplegia Complete paraplegia
 - Incomplete quadriplegia Complete quadriplegia

- 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

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

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?

- Date of diagnosis: _____
- Note the type of treatment:
 - Coumadin
 - Aspirin
 - Heparin
 - Hospitalization Date: _____

- 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

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
