

Agent Name: \_\_\_\_\_ Agent Phone: \_\_\_\_\_ Agent Email: \_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

☐ Male ☐ Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:** ☐ Never used ☐ Totally stopped Date stopped: \_\_\_\_\_ ☐ Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:** ☐ Term ☐ UL ☐ Survivor **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

### FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

***If yes, use separate sheet to provide this information, including age of onset and date of death***

### PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnoses: \_\_\_\_\_

2. What stage was the cancer?

☐ Stage 0 (in-situ) ☐ Stage Ia ☐ Stage Ib ☐ 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

***The above information is for preliminary underwriting purposes only and will not be made part of any contract.***