

**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. 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

\_\_\_\_\_

\_\_\_\_\_