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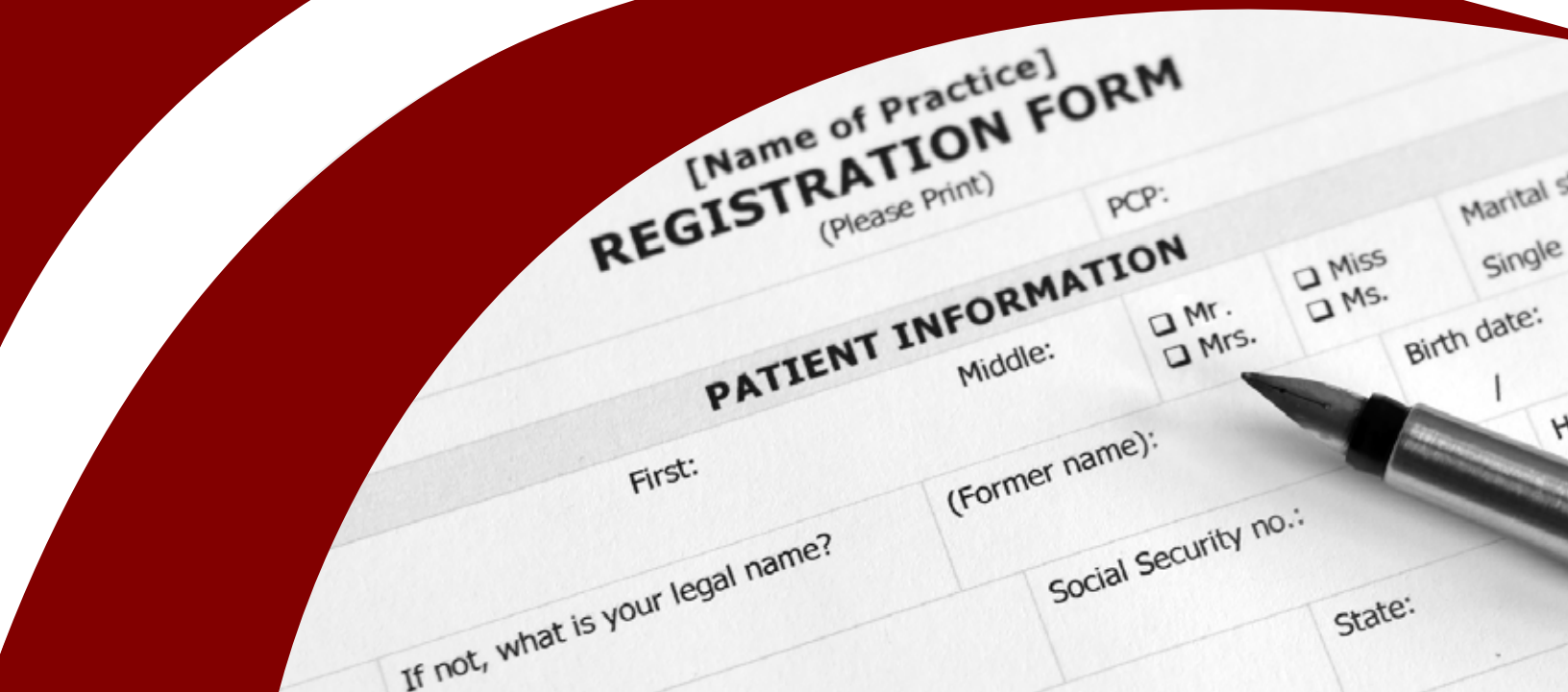
FIELD UNDERWRITING GUIDE



Field Underwriting Guide, Version 3.0

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How to Use This Guide

This NAILBA Field Underwriting Guide had been produced specifically with you, the producer, in mind. We believe it is a highly unique educational and practical resource that can save you time and earn you more money. The best practices included here can truly improve your chances of having your business placed quickly and easily!

- Highlight key points of your app for faster underwriting (Page 4)
- Quickly check applications to make sure they are fully complete (Page 8)
- Set and manage expectations with your client (Page 11)
- Ensure you gather the right information for every case (Page 15–16)
- Understand risk factors and how to optimize the medical assessment process (Page 17)

Created by a group of experienced industry professionals representing each of the entities involved in the insurance application process, this Guide has been created to be a practical, hands-on resource for you to put to use as you work through an application. It is also intended to be a long-term reference tool, giving you a full perspective on the important steps to acknowledge and the distinct roles of the carrier, the Brokerage General Agency, and you, the producer, in the application process.

Whether you are new to the business or a seasoned veteran to writing apps, we believe this Field Underwriting Guide can be a great "sidekick" as you seek to improve your production levels. It can be called upon for the consistency and the competitive edge you need to increase your percentage of successfully written business. We think that following these guidelines will increase the placement of your business by 10 to 20 percent, resulting in thousands of additional sales dollars.

So don't just tuck this away on the shelf!

Take a few minutes to review this guide. Start using the interactive tools to improve the way you sell and write your business today!

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Table of Contents

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Dear Valued Producer,

This guide will help you do the best basic field underwriting possible and prepare you for meetings with clients with a variety of medical histories.

Using this guide, you will be able to gather the right information, ask the right questions, and set clear expectations with your client. Use this guide to increase your ability to obtain coverage for your clients that meets their expectations.

- **Fact Finder and Generic Underwriting Criteria:** The fact finder (p. 15) and the generic underwriting criteria (p. 17) will help your brokerage general agency find the best carrier prior to formal submission. Impaired risk cases are the most difficult cases to quote.
- **Common Medical Impairments Summary:** Accurate information enables you or your Brokerage General Agency to select the best carrier for your client and determine which risk class to quote. Please use the common medical impairments summary (p. 18); this summary will help guide you in asking the right questions on medical conditions. Once you determine which carrier will best suit your client, the application process begins.
- **Forms Checklist:** The best means of communicating with the underwriting department at the insurance carrier is through the application. Our handy forms checklist (p. 8) can be used to make sure important documents are not missed. Thorough completion of each application can save weeks of additional underwriting time and will result in higher placement. The checklist will also help you deliver the policy and receive your commission checks sooner.
- **Setting Clients Expectations:** It is always best to set expectations (p. 11), and using our guide will enhance the communication between yourself, the client, and the agency. Underwriters with all carriers depend on you to make sure the information on the application is complete, detailed, and accurate, and that all the relevant information about the applicant's situation is provided even though it might not be initially required on the application. After all, your time and effort getting the sale should not be wasted on a poorly completed application, which will result in delays or worse yet, a not-taken policy.
- **Cover Letter:** A cover letter (p. 6) is an excellent way for you to clarify a situation or provide the underwriter with additional information about your client. If you have information that will give a more complete picture of the person or present a favorable impression, do not hesitate to submit it.

What should your cover letter include? Highlight the factors that would not be developed through the application, current exam, attending physician statements, or an inspection report. For example, if your client has a history of a heart attack, highlight the favorable lifestyle changes that he/she has made since the event—weight, cholesterol and blood pressure control, smoking cessation, a daily aspirin, and exercise 3 times per week.

Five minutes of your time can shave days or even weeks from the underwriting process!

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To: Underwriter @ XYZ Company:

- How well do you know the client and the client's business? Have you done any business with the client in the past? Were they referred to you by another client? Is the client a key center of influence for future business?
- How did the sale develop? What is the purpose of the coverage (income replacement, key-person, buy-sell, estate preservation, etc.)?
- How were the plan of insurance and face amount determined? Provide any assumptions or formulas used to determine the amount. Include copies of any financial planning documents.
- Are other business partners applying for coverage? If not, explain why.
- If a loan is involved, what is the amount and duration of the loan?
- Is this a new business venture? Does the client have any prior business experience that would contribute to this new venture's success?
- Is the case being shopped to other carriers? Which carriers? What offers have you received? What is the client's premium tolerance? What is the total line of coverage, and how much will be placed with each carrier?
- Any history of bankruptcy or reorganization? Chapter filed? Date of discharge?
- Does the client have any special circumstances with his or her dependents?
- Are there any factors in the client's history that may present a problem or even help with underwriting?
- Any underwriting concerns? Lifestyle changes that he/she has made? (This is especially important when dealing with older-age clients)
- Is the client physically active or involved in any religious/community organizations?
- Has the client traveled to countries longer than two weeks? Any upcoming travel?
- Has the client participated in avocations such as aviation, rock climbing, etc.?
- Has the client ever been rated or declined in the past?
- Are you in competition with another broker for the case?
- Have CPAs, attorneys, or trustees been involved in the case? What is their role? Do you expect any changes before or after issue based upon recommendations from the client's advisors?
- Is the client a nonworking spouse? If so, make sure to address amount of coverage on working spouse and the annual income for that working spouse as well.

Is Your Business Profitable?

Using placement ratio, carriers are looking at agents as either profitable or not profitable parts of their field force. Brokerage General Agencies (BGAs) also look at their business to see if it's profitable, as agents do as well. Cases that are not placed are not profitable for anyone, and carriers are now starting to penalize BGAs with low placement ratios by dropping commissions, or worse, terminating contracts with brokerage agencies and agents. The current industry average of not placed cases is between 25 and 35 percent.

The hardest part of an agent's job is getting the sale. The next major hurdle is getting the formal application completed and mailed to the BGA; after that, most of the work of getting a policy issued will be done by the BGA and carrier.

- How many prospecting calls do you have to make to get just ONE appointment?
- From the appointments you obtain, how many turn to follow-up appointments?
- How much of your time is spent on determining need and adjusting products?
- How many follow-up visits do you make?

A lot goes into getting that one application! Finally, when you are done and ready to send this application to your BGA, most of your work is completed.

What if you don't place that case? This is lost time, money, and effort for you, the BGA, and the carrier. Medical records have been paid for, underwriting requirements have been obtained, underwriters and doctors have reviewed the case. Everyone involved has made an investment in the case for no return.

Use this guide, ask the right questions, complete ALL questions on the application, and set realistic expectations up-front for your client.

All of this can make the difference between an expedited paid case and a failed opportunity.

It's not how many cases you submit. It is how many are paid!

"What's all this worth?"

If you can reduce your case cycle time by 8 to 10 days, then you could see a dramatic increase in your placement percentage.

If you spent an extra five minutes per case, you could increase your placement ratio by 5 percent, and your gross income would increase by approximately $12,000 per year! This is based on 100 cases per year with an average gross profit of $2,300. This means spending another 8 hours or so each year and earning an additional $1,500 for each hour spent.

Think of how much better you feel when your time prospecting results in more sales.

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FORMS CHECKLIST TOOL

Completion of a Forms Checklist will accelerate the underwriting process as much as 10 to 15 days.

Application (Part 1)

- ☐ Signed by Agent, Proposed Insured, and Owner.
- ☐ When applicant is a child, the parent must sign as the Proposed Insured on all forms.
- ☐ When a business is the Owner, an officer other than the client MUST sign the application as
- ☐ Owner. Include his/her title when signing for the business.
- ☐ When the Owner is a Trust, the application MUST be dated after the Trust date. Also, be sure to include tax ID#. All trustees should sign the application.
- ☐ If a corporation is the owner, make sure to include tax ID#.

Non-Medical (Part 2)

- ☐ At most, complete all doctor information and impairments; these two items will shorten the underwriting process.

HIV Consent

- ☐ Your General Agent will have correct form numbers for the resident state of the applicant.

HIPAA Authorization

- ☐ Signed HIPAA Authorization Form

Replacement Form(s)

- ☐ Your General Agent can verify proper forms for the state in which this application is being signed and delivered.

Questionnaires

- ☐ Special questionnaires may be required for some activities. Your General Agent can assist you with the correct form.

1035 Forms

- ☐ Please submit originals.

State-Specific Forms

- ☐ Proper forms for the state in which this application is being signed and delivered can be verified with your General Agent.

Financial Information

- ☐ When a business is the Owner, please include business financial statements to include Balance Sheets, Income Statements, and Cash Flow Statements (if available) for at least the last two years to demonstrate a track record for the company.

Cash with Application

- ☐ Checks need to be made payable to the Insurance Carrier.
- ☐ Ensure your client's coverage is bound by verifying with your General Agent the specific rules for each Carrier.
- ☐ Completed Limited Insurance Agreement when submitting cash with application.

Underwriting Requirements:

- ☐ Schedule the paramed, labs, EKG, and all medical requirements.

- **Universal Life Cases:**
- **Certification of Non-Illustration or Acknowledgment of Non-Illustration**

- ☐ NAIC regulations require the illustration to be dated on or prior to the application signed date.
- ☐ If a signed illustration is not collected at time of application, a Certification of Non-Illustration or Acknowledgment of Non-Illustration must be completed.

Formula and Guideline for Amounts of Insurance (Financial Underwriting)

Each carrier has its own specific guidelines. This information is meant to give you a general guideline to help you in the Financial Underwriting process. See specific carrier guidelines or check with your General Agency to determine if third-party financials are needed.

What Is Financial Underwriting?

Financial underwriting is the analysis of an individual's financial situation which takes place every time a life insurance case is underwritten. The purpose of this evaluation is to determine the need for insurance and to make sure the amount of insurance applied for is reasonable and in line with the insured's needs.

Purpose	Formulas and Guidelines	Pertinent information in a cover letter to accompany the application
Personal Insurance—Replacement of Income	**Age** — **Factor times income** 20–35 — 20 to 30 36–40 — 15 to 25 41–45 — 14 to 20 46–50 — 12 to 20 51–59 — 10 to 15 60–64 — 7 to 10 65–70 — 4 to 10 70+ — 4 to 5	A cover letter explaining: Purpose and need for coverage's How amount was determined Details on earned and unearned income
Children's Coverage	Up to 50% of parents' coverage *Some carriers only offer maximum of $250,000. Check with your BGA for details.	Need for coverage If there is more than one child in the family, they should all be insured for similar amounts. If not, an explanation should be given.
Debt Protection (Personal)	100% of home loan 50% to 75% of loan balance for other types of loans	Reason for loan Duration and amount of loan Identity of lender Status of loan (pending or approved)
Debt Protection (Business)	50% to 75% of loan balance	Same as personal loan with the addition of: Business financial statements Explanation of why the proposed insured is key to the dept repayment
Charitable Contributions	Based on contribution history and personal needs having been met	Details of association with charity Details of personal insurance Details about organization if not well known Organization's tax-exempt number Reason for purchase
Key Person	Up to 10 times annual income	Description of why this is a key person Details of coverage on other key staff Other details: Proof of total compensation Employment contract

HELPFUL HINTS FOR THE BROKER

Through the application process, remember to:

1. Explain the application, set expectations on how long it might take, and explain the "life cycle of an application."
2. Explain to your client the medical exam and inspection process.
3. Complete limited insurance agreement when submitting cash with application.
4. To ensure the best exam results, encourage your client to:
   - fast for at least 12 hours prior to the exam.
   - avoid foods that are high in salt.
   - avoid alcohol for at least 8 hours before the exam.
   - avoid strenuous exercise for at least 12 hours prior to the exam.
   - avoid tobacco for at least one hour prior to the exam.
   - bring a list of all current medications, including dosages, name, address, and phone number of the physician prescribing the medications.
   - If a stress test is required, advise your client to wear comfortable clothing and athletic shoes.
5. Fully answer all questions on the application, and use your client's full legal name.
6. Write legibly using black ink. Take your time and write the information so that it can be read.
7. Document Aviation, Avocation, and Foreign Travel. (Check with specific carrier at time of application for specific forms, and check with state for compliance regulations related to foreign travel)
8. Explain the insurable interest and financial justification.
9. Make sure the application is signed by you, your client, and the policyowner(s).
10. Foreign citizenship of client—make sure to address country that client is a citizen of, provide copy of visa (type and expiration), provide copy of green card, or supply green card number.
11. Complete the Part 2, medical information section of the application:
    - Ask probing questions—Ask about the frequency of the condition; date of diagnosis, treatment given, and by whom. Also include start and stop dates, if recurrent.
    - Use concrete terms—Be specific about treatment and medications, using accurate spelling, dosage, and reason for medication
    - Provide details of all treatment—Give start and end dates all medical treatment for the past 5 years.
    - Provide physician information—List full names, addresses, and phone numbers for all physicians consulted.
    - Provide details of any cognitive or functional tests during the past 5 years

A properly completed application with medical information can help to speed the underwriting process along and will not leave the prospect wondering, "What's going on with my application?"

The Insurance Exam: Setting Client Expectations

Example of form/letter to provide to your client:

An examination will be required when applying for life insurance. The degree of testing is determined by your age and the amount of insurance you have applied for. The exam can consist of any of the following:

- Health history
- Vital signs, to include blood pressure, pulse, height, weight, and chest measurements (for males only)
- Urine sample
- Blood sample
- EKG or treadmill
- Doctor examination (an exam performed by a doctor)
- Chest X-ray (due to certain ages, face amounts, and smoking status)

The exam is performed by an approved paramedical facility. They will contact you to make an appointment that is convenient for you. The examiner will advise you of what the exam will consist of from the list noted above and advise you of any necessary instructions.

Please note the following before taking your exam:

- Try to relax prior to the exam.
- Please fast for at least 8 hours prior to the exam.
- Avoid strenuous exercise for at least 12 hours prior to the exam.
- Try to abstain from the use of stimulants at least 1 hour prior to the examination (smoking, coffee, tea, soft drinks, or anything containing caffeine).
- Alcoholic beverages should not be consumed for at least 12 hours prior to the exam.
- Please prepare a list of doctors' names and addresses that have been seen in the last few years.
- Bring a list of all current medications, including dosages, as well as the name, address, and phone number of the physician prescribing the medications.
- Please bring a photo ID (driver's license).

There is no cost to you for the exam. If you would like a copy of your lab results, please write and sign a short note addressed to the carrier where you are applying for life insurance, indicating you would like a copy of your lab results sent to you. We will forward to the carrier.

Example of letter to client after taking application, thus setting the expectations the client should have when applying for life insurance.

WELCOME "ABC" Company

(Date)

(Client Name)
(Address)
(City, State, Zip Code)

Dear (Client Name):

Thank you for placing your confidence in us. We are committed to providing you with the best service in the business.

We have completed our in-house process and have forwarded your application(s) to (Company Name or Names) for medical history review and underwriting approval. Every week, we will communicate with the carrier on your case. Once all requirements are received and the policy is issued, we will be calling you to make arrangements to deliver the new policy. During the underwriting process, we may be in contact with you if the carrier requests additional information or clarification.

Note: Please be advised that the time between when an application is submitted and a policy is issued varies based upon several factors and could take anywhere from 4 to 8 weeks. This all depends on when the exam is completed; if there are medical records that need to be obtained from your doctor, and if any additional forms/questionnaires are being requested by the underwriter.

We will work to expedite the handling of your application, as our primary goal is your satisfaction! In the meantime, please do not hesitate to contact us with any questions or concerns. You may reach us at 505-555-1212.

Thank you again for your business with ABC.

Best Wishes,

Broker Name
Registered Representative
Company Name

CHART OF ROLES & RESPONSIBILITIES

Agent:

- Initiates contact with applicant and maintaining that relationship
- Collects client's financial and medical information
- Field underwriting and initial assessment of need
- Educates client on the case life cycle; setting expectations
- Workes with agency to obtain best solution for client
- Begins formal application process with client
- May order paramed exam

BGA:

- Illustration Software (Administrator to Broker)
- Promotes carrier products to agents
- Compensation awareness
- Educates and trains agents about the cycle of case; provides expectations
- Field Underwriting—utilizing underwriting guidelines information from carriers to assess products for client; work with Agent to determine best possible solution for client
- Ensures completeness of application package prior to submission to Carrier
- Timely ordering of requirements
- Ensures agent is properly licensed
- Provides clear and timely communication with Broker

Carrier:

- Designs products
- Legal and compliance
- Advanced sales support and concepts
- Policy service
- Policy risk assessment and policy delivery
- Provides consistent, timely responses with the best possible offer the first time
- Promotes new products through various communication tools
- Communication regarding product changes, state changes, legal changes
- Designs/maintains producer and BGA compensation payments and bonus programs

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QUICK FACT-FINDER TOOL

All personal information protected by HIPAA regulations (see HIPAA Form attached with supplemental forms)

Completion of a FACT FINDER will accelerate the underwriting process

Agent name: _____

Agent phone number _____ E-Mail Address: _____

Proposed Insured's legal name: _____ Date of Birth/Age: _____

Plan of Insurance requested:

Individual: ☐ Term ☐ UL ☐ VUL ☐ WL **Survivorship:** ☐ SUL ☐ SVUL ☐ SWL

Rate Class Desired

☐ Best Rate

☐ Preferred

☐ Standard

☐ Rated: _____

Has this case been discussed or submitted to your BGA on a preliminary, trial, or informal basis? ☐ Yes ☐ No

Client's budget: $ _____

Present Nicotine Use:

☐ None ☐ Cigarettes—frequency of use per day: _____

☐ Cigars ☐ Pipe ☐ Dip ☐ Chew ☐ Nicotine Gum ☐ Other: _____

Quantity per month _____

Former Tobacco Use: List each type of tobacco, quantity and frequency used, and date of last use: _____

_____

Build: Height: _____ feet ____ inches Weight: _____pounds

Family History *(Family history is a consideration for each rate class):*

To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60 due to cardiovascular disease, cerebrovascular disease, diabetes, or cancer? ☐ Yes ☐ No

If yes, provide full details with impairment, age at onset and age at death if deceased:

☐ Father: _____

☐ Mother: _____

☐ Siblings: _____

Blood Pressure and Cholesterol:

Latest BP reading: _____/_____Latest total cholesterol: _____mg Latest cholesterol/HDL ratio: _____

Are you currently taking any medication for blood pressure? ☐ No ☐ Yes, Name of medication: _____

Are you currently taking any medication to lower cholesterol? ☐ No ☐ Yes, Name of medication: _____

QUICK FACT-FINDER TOOL—CONTINUED

Aviation/Avocation:

In the past 5 years have you or do you intend to participate in any of the activities listed?

☐ None ☐ Flying ☐ Racing ☐ Sky diving ☐ Scuba diving ☐ Other

Details: _____

Citizenship/Residency/Travel:

US Citizen: ☐ Yes ☐ No

If no, provide type and expiration date of visa, green card status, and length of time in USA: _____

_____

Any future plans to live or travel outside the USA? *check with your Brokerage General Agency regarding state compliance prior to completing any application(s) ☐ No ☐ Yes (provide purpose, cities, countries, frequency, and duration): _____

_____

Driving History:

Have you had any of the following motor-vehicle-related incidents in the past 10 years?

☐ Moving violation ☐ Reckless driving ☐ DWI or DUI ☐ License suspension ☐ License revoked

Provide dates, details: _____

Medical History:

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply:

- ☐ Alcohol abuse
- ☐ Alzheimer's/dementia/cognitive impairment
- ☐ Asthma
- ☐ Cancer
- ☐ Cirrhosis
- ☐ COPD
- ☐ Coronary artery or cerebrovascular disease
- ☐ Crohn's disease
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Heart murmur/valve disease
- ☐ Hepatitis
- ☐ Irregular heartbeat/palpitations
- ☐ Kidney disease
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Peripheral vascular disease
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Other

List dates, diagnosis, details, treatment, plus names, addresses, and phone numbers of all physicians consulted
(Refer to Common Medical and Non-Medical Impairment sections for critical underwriting factors):

_____

_____

_____

_____

_____

_____

_____

GENERIC UNDERWRITING CRITERIA

REFERENCE TOOL (See Below to Pre-Qualify Your Applicant)

	BEST Best Rates	BETTER Preferred Rates	GOOD Preferred and Standard
No Nicotine Use	5 years	Usually 3 years	Usually 1 year
Family History	No cardiovascular or cancer in parents or siblings before age 60	No cardiovascular or cancer death in parents before the age of 60	No cardiovascular death of more than one parent before the age of 60
Aviation / Avocation **assuming the activity to be excluded is not the primary source of revenue*	Usually available with a flat extra or exclusion	Available with a flat extra or exclusion	Available, but may have a flat extra or exclusion
Blood Pressure	Current BP cannot exceed 140/85, may vary over 60 not available with treatment.	Current BP cannot exceed 140/90, may vary over 60, with or without treatment.	Current BP cannot exceed 155/94, may vary over 60, w/w/o treatment
Cholesterol or Cholesterol/HDL Ratio	Maximum 220. HDL ratio not to exceed 5.0 (with or without medication)	Maximum 250. HDL ratio not to exceed 6.0 (with or without medication)	Maximum 300. HDL ratio not to exceed 8.0 (with or without medication)
Cancer History	Not available. Possible exception: Basal cell cancer (skin)	Not available. Possible exception: Basal cell cancer (skin)	Usually available after 7 yrs. for most carriers
Heart Disease	Not Available	Not Available	Usually not Available
Driving History	No DUI, reckless driving, or suspension for 5 yrs.	No DUI, reckless driving or suspension for 5 yrs.	No DUI, reckless driving or suspension for 2 yrs.
Should you have any questions, please contact your Brokerage General Agency.			

Maximum Build Chart

HEIGHT			
Male/Female	Preferred Plus	Preferred	Standard
5'0"	145	161	189
5'1"	149	165	193
5'2"	153	170	197
5'3"	158	175	204
5'4"	162	180	209
5'5"	166	185	215
5'6"	170	190	220
5'7"	176	195	225
5'8"	182	200	230
5'9"	188	205	235
5'10"	193	210	242
5'11"	199	216	251
6'0"	205	222	256
6'1"	211	229	263
6'2"	216	236	271
6'3"	222	243	279
6'4"	227	250	286
6'5"	233	257	293
6'6"	238	264	300

CONDITION	UNDERWRITING FACTORS
Alcohol: Alcohol abuse, addiction or dependency leading to social, medical, and legal issues. Alcoholics have an uncontrollable need for alcohol and continue drinking despite adverse social and occupational consequences. If client has received treatment in the past and uses any alcohol currently, do not submit an application	**History of Condition:** • When did condition begin? • Time since stopped drinking? • Relapses? Date of last drink? • Reason for stopping? • Traffic violations or legal problems caused by alcohol? • Stable job and home life? **Treatment/Therapy:** • Hospitalization required? • In/out-patient therapy? • Member of AA or support group? • Any use of Antabuse? **Current Condition:** • Normal blood studies? (i.e. Liver) Function tests: SGOT, SGPT, GGTP **Related Issues:** • Client treated for drug problem? • Court-appointed treatment?
Alzheimer's Disease: Dementia caused by degeneration of the brain resulting in loss of cognitive function, memory loss of recent or past events, personality and mood changes.	**History of Condition:** • Onset date of symptoms? • Severity? • Impaired judgment? • Rate of progression? • Activities of Daily Living? • Living independently? • Any assistance required? • Medication: type and dosage? • Any other medical conditions?
Anemia: Decrease in the number of red blood cells or hemoglobin in the blood due to blood loss, decreased production in the bone marrow, or increased destruction (hemolysis) of red blood cells.	**History of Condition:** • Date of diagnosis? • Type of anemia? • Cause of anemia? • Treatment—type and dosage? • Recent red blood count (RBC), hemoglobin (Hgb), and mean •corpuscular volume (MCV) results? • Any other medical conditions?

Aneurysm: An aneurysm is a dilation or ballooning in the wall of an artery that can be caused by atherosclerosis or uncontrolled blood pressure. Rupture of the aneurysm can be life-threatening. Aneurysms can be found in any artery, but the most common are: • Aortic—abdominal or thoracic • Cerebral • Atrial or ventricular	**History of Condition:** •Type of Aneurysm •Date of Initial Diagnosis? •Dates of imaging studies, and size at each test •Stable in size or increasing? If stable, for how long? •Treated surgically? If so, what type of treatment, and date? •Smoker? If previously a smoker, how long since quit? •Other health issues (pain in legs when walking? Elevated Cholesterol? Hypertension? Diabetes? CAD or Cerebrovascular Disease?) •Medications?
Angina Pectoris	See Coronary Artery Disease
Angioplasty	See Coronary Artery Disease
Anorexia Nervosa: A psychiatric disorder characterized by a fear of obesity, low body weight, and a distorted body image.	**History of Condition:** • Date of diagnosis? • Age at diagnosis? • Current and prior height/weight? • Type of treatment? • Hospitalization required? • Medication: type and dosage? • Does client have a normal lifestyle now? • Length of recovery? • Any other mental health disorder/issue?
Anxiety Disorders: Anxiety neurosis, phobias, and obsessive compulsive disorders	**History of Condition:** • Date of diagnosis? • Severity of disorder? • Frequency of any panic attacks? • Type of treatment? • Medication: type and dosage? • Dates of any suicidal thoughts or attempts? • Dates of any hospitalization(s)? • Functional and/or recovered? **Related Issues:** • Driving history?
Arrhythmia: Deviation from the normal rhythm of the heart. Specific arrhythmic impairments include: Sinus bradycardia, sinus tachycardia, paroxysmal tachycardia, paroxysmal atrial tachycardia, paroxysmal ventricular tachycardia, sick sinus syndrome, irregular/ectopic pulse, atrial fibrillation, atrial flutter, ventricular fibrillation, and wandering pacemaker.	**Description of Condition**: • Date of diagnosis? • What is the specific arrhythmia? • Cause of arrhythmia? • Dates of first and last attack? • Frequency of episodes? • Client's symptoms? • Any associated conditions/health problems? **Treatment:** • Dates and type of treatment received? • Medication: type and dosage • Any complications from treatment? • Does client have a pacemaker?
Arteriosclerosis	See Coronary Artery Disease

Asthma: Lung disorder characterized by reversible obstruction of the bronchi (bronchospasm) or increased hypersensitivity of the airways to various stimuli (allergens, dust, chemicals, exercise, or cold air). Symptoms include coughing, shortness of breath, and intermittent wheezing.	**History of Condition:** • Date and age at diagnosis? • Type and severity? Any status asthmaticus? • Results of pulmonary function tests (FVC and FEV1)? • Frequency of attacks? Dates of first/most recent attacks? • Any hospitalization or ER visits? • Medication: type and dosage? • Client's occupation? • Current and prior smoking history?
Barrett's Esophagus	See Esophagus
Build: Overweight, underweight, or rapid weight loss	• Client's height and weight? • Weight gain/loss in past year? • How and why did weight change? • Gastric bypass? • How long has current weight been maintained? • Any other impairments or conditions?
Bulimia Nervosa: A psychiatric disorder characterized by self-induced vomiting, use of laxatives or diuretics, binge eating episodes, and a preoccupation with body image.	**History of Condition:** • Date of diagnosis? • Age at diagnosis? • Current and prior height/weight? • Type of treatment? • Hospitalization required? • Medication: type and dosage? • Does client have a normal lifestyle now? • For how long? • Other psychiatric disorders?
Bypass Surgery	See Coronary Artery Disease
Cancer: Cancer, neoplasia, and malignancy are interchangeable terms used to describe a pathological condition of cellular growth that is invasive and has a tendency to metastasize (spread to other parts of body). Prognosis varies by tumor type, stage, and grade.	**History of Condition:** • Type and location of cancer? • Date of diagnosis? • Pathology results: tumor size, stage, and grade? • Did cancer spread (metastasize)? Where? **Treatment:** • Describe treatment and start/end dates (including surgery, •chemotherapy, and radiation) • Medication: type and dosage; start/end dates? **Current Condition:** • Recurrence? • Results of interim testing? • Date and outcome of last physician visit?

Cerebrovascular Disease: • Cerebral vascular accidents (CVA) or strokes resulting from interruption of blood flow to the central nervous system. Causes include: • Thrombosis due to atherosclerosis • Embolism • Hemorrhage due to aneurysm • Hypotension (low BP) due to arrhythmias • Vasculitis • Transient ischemia attack (TIA) is a short interruption in blood supply to a portion of the brain, resulting in temporary neurological symptoms usually lasting 24 hours or less. TIAs frequently precede a Stroke.	**History of Condition:** • Type and dates of episodes? • Underlying cause, if known? **Tests and Treatment:** • Treatment and surgical history? • Medication: type and dosage • Results of carotid ultrasound, angiography, Stress EKG treadmill testing, coronary angiogram, and echocardiography? **Current Condition:** • Current medical status? • Residual side effects/ impairments? • Any other medical problems or issues with circulation? • Current and prior smoking history?
Cirrhosis	See Liver Disorders
Congenital Heart Disease: Congenital heart disease is a type of defect or malformation in one or more structures of the heart or blood vessels that occurs before birth. Congenital heart defects may produce symptoms at birth, during childhood, and sometimes not until adulthood. Examples include: • Coarctation of the aorta • Patent ductus arteriosus • Tetralogy of fallot • Atrial and ventricular septal defects	**History of Condition:** • Type of congenital abnormality? • Severity? • Treatment including dates and type of any surgical procedures? • Any heart enlargement? • Any arrhythmias? • Any residual issues postsurgery? • Medication: type and dosage? • Any other medical conditions? • Current and prior smoking history?
COPD (Chronic obstructive pulmonary disease) / Emphysema / Chronic bronchitis / Chronic obstructive lung disease (COLD): Chronic obstructive pulmonary disease (COPD) is a group of lung diseases where airflow through the airways leading to and within the lungs is partially blocked, resulting in difficulty breathing. As the disease progresses, breathing becomes more difficult and complicates normal activities. • Chronic bronchitis: Inflammation occurs in the bronchial tubes. • Emphysema: Permanent lung damage to the air sacs (alveoli) at the end of the airways. COPD is a gradually progressive disease with more rapid progression in individuals who continue to smoke. In many individuals with COPD, the airway obstruction is partially reversible in response to bronchodilators.	**History of Condition:** • Date of diagnosis? • Medication: type and dosage? • Results of pulmonary function tests (FVC and FEV1)? • Shortness of breath at rest or with exercise? • Chest X-ray results? • Any heart condition or arrhythmias? • Oxygen use? • Is client underweight? • Current and prior smoking history?

Coronary Artery Disease: Restriction of oxygen to the heart cause by atherosclerosis (narrowed arteries), thrombosis, or spasm. When blood flow becomes compromised due to stenosis, it leads to symptoms of chest pain (a.k.a. angina or ischemia). Plaques can rupture and release debris that prompts the formation of blood clots, a common cause of heart attacks and strokes. If the plaque blocks the artery completely, the area of the heart that is being supplied by the artery dies, resulting in a myocardial infarction (heart attack).	**History of Condition:** • Date of diagnosis? • Onset age? • Severity of disease—Number and names of vessels affected? • Surgical history—bypass or angioplasty (with or without heart •stent)? • Medication: type and dosage? • Dates and results of angiograms, stress tests, and perfusion •studies? • Ejection fraction (EF) > 50%? • Any symptoms post-operatively? • Blood pressure and cholesterol levels? • Active lifestyle? • Family history of early death from coronary disease? • Current and prior smoking history?
Crohn's Disease: Crohn's disease may also be called ileitis or enteritis. Crohn's disease usually occurs in the lower part of the small intestine, called the ileum, but it can affect any part of the digestive tract, from the mouth to the anus. Attacks can be chronic or isolated. Complete remission can occur, but surgery is frequently required due to failure of drug therapy or complications. Crohn's can recur post-operatively.	**History of Condition:** • Date of diagnosis? • Frequency and severity of attacks? • Date of last attack? • Type of treatment received? • Hospitalization or surgery? • Medication: type and dosage? • Any ongoing symptoms orcomplications? • Underweight or anemic?
Depression: •Manic depression/Bipolar disorder: cyclical swings between elation and despair. •Reactive depression: depression caused by an external situation that is relieved when situation is removed.	**History of Condition:** • Date of diagnosis? • Cause of depression? • Type of treatment? • Dates of any hospitalization? • Medication: type and dosage? • Dates of any suicidal thoughts or attempts? • Functional and/or recovered? **Related Issues:** • Driving history?

Diabetes Mellitus: A chronic disease occurring when the pancreas does not produce enough insulin. The body's ability to utilize carbohydrates and break down fats is reduced. Sugars build up in the blood and urine, leading to complications affecting the heart, brain, legs, eyes, kidneys, and nerves. Uncontrolled diabetes can result in angina, heart failure, stroke, leg cramps on walking (claudication, peripheral vascular disease), poor vision, renal failure, and damage to nerves (neuropathy). The diagnosis of diabetes is made when an individual has high blood sugar levels in the blood, increased thirst, urination, hunger, frequent infections, or signs of any of the complications associated with diabetes. To confirm a diagnosis, physicians will measure the level of a protein in the blood, hemoglobin A1C (a.k.a. glycolated or glycosylated hemoglobin). **Types:** • Type 1, Insulin dependent (IDDM), Juvenile onset diabetes • Type 2, Non-insulin dependent (NIDDM), Adult onset diabetes •mellitus (AODM)] • Gestational diabetes • Pancreatic failure	**History of Condition:** • Date of diagnosis? • Type of diabetes? • Client's age at onset? **Tests and Treatment:** • Medication: type and dosage? • How often does client test sugar levels at home and visit his/her •doctor? • Date of last visit? **Current Condition:** • Degree of control? • Latest and average of hemoglobin A1C readings? • Any complications or other medical impairments? • Overweight? • Current and prior smoking history?
Diverticulosis and Diverticulitis: Diverticula are small pouches that form through the muscular layer of the intestinal wall. Diverticulitis is the inflammation of one or more of these pockets. Complications include abscess, fistula, or obstruction of the colon that require surgery.	**History of Condition:** • Date of diagnosis? • Frequency and severity of attacks? • Date of last attack? • Hospitalization or surgery? • Medication: type and dosage? • Any ongoing symptoms or complications?
Drugs: A chemical substance that alters mental, emotional, or bodily function. Usually applied to narcotics, it also includes prescription drugs, which can be abused when dosages are exceeded.	**History of Condition:** • Type of drugs used by client? • Amount? • Frequency of use? • How long client has been clean? • Any relapses? • History of drug overdose? **Treatment:** • Rehab program? • In/out patient? • Duration of stay? **Related Issues:** • Use or abuse of alcohol? • Suffer from depression? • Stable job and home life? • Any other medical problems? • Traffic violations or legal problems caused by drug use?

EKG and Stress EKG Abnormalities: Electrocardiograms measure the electrical activity of the heart through special sensors placed strategically on the chest, arms, and legs. The electrodes are connected to a machine that translates the electrical activity into line tracings on paper. The tracings are analyzed by the machine, the physician, skilled underwriters, or nurses. A resting EKG may suggest: • Problems with heart rhythm or rate (arrhythmias) • Heart enlargement • Inflammation of the lining of the heart (pericarditis) • Insufficient blood flow (ischemia) • Prior injury (myocardial infarction) • Electrical abnormalities caused by electrolyte imbalance in the body. Stressing the heart through exercise (treadmill or bike) or using a medication increases the heart rate, blood pressure, and demand on the heart muscle. Ischemia may occur during exercise in areas of the heart supplied by narrowed coronary arteries. Other symptoms (shortness of breath, chest pain, claudication) can be strong predictors of this or other vascular impairments.	**History of Condition:** • Onset date of abnormalities? • Type of abnormality? • How long have the findings been stable over time? • Results of any advanced testing: i.e., resting or stress •echocardiograms, MUGA, thallium stress tests, angiograms, •doppler? • Any underlying vascular disease?
Emphysema	See COPD
Epilepsy/Seizures: Abnormal discharges within the brain characterized by recurring attacks of motor, sensory, or psychic malfunction, with or without loss of consciousness, convulsive movements, and urinary incontinence. Seizures can cause falls, drowning, and accidents. A prolonged seizure condition called status epilepticus can lead to coma or death.	**History of Condition:** • Type: grand mal/petit mal? • Dates of 1st/most recent attacks? • Number of attacks per year? • Type of treatment received? • Medication: type and dosage? • Client's occupation? • Any traffic violations or incidents?

Esophagitis: Inflammation of the esophagus is a complication of gastroesophageal reflux disease (GERD). If GERD is left untreated, esophagitis can cause bleeding, ulcers, and chronic scarring. This scarring can narrow the esophagus, eventually interfering with swallowing. Chronic or longstanding GERD can lead to Barrett's esophagus. Barrett's esophagus results when the normal cells of the esophagus are replaced with cells similar to those of the intestine. It is a precancerous lesion that increases the risk of esophageal cancer.	**History of Condition:** • Date of diagnosis? • Details/type of treatment? • Hospitalization or surgery? • Results of upper GI series and endoscopies? Any Barrett's? • Medication: type and dosage? • Any ongoing symptoms or complications (i.e., hemorrhage or perforation)? • Underweight or anemic? • Current and prior alcohol use—type, quantity, and frequency? • Current and prior smoking history?
Fatty Liver	See Liver Disorders
Fibrocystic Breast Disease: Generalized breast lumpiness, also called fibrocystic breast changes or benign (noncancerous) breast disease.	**History of Condition:** • Date of diagnosis? • Any hyperplasia or dysplasia on biopsy? • Any personal or family history of breast cancer? • Breast exams and mammograms performed regularly?
Gilbert's Disease (Familial Hyperbilirubinemia): Gilbert's Disease is a benign, hereditary condition disorder leading to a defect in the removal of bilirubin from the liver. Blood tests reveal elevated unconjugated/indirect bilirubin. Most people avoid serious health problems for normal life expectancy.	**History of Condition:** • Date of diagnosis? • Results of any liver biopsies or ultrasounds? • Past and recent liver function test results—bilirubin, alkaline phosphatase, SGOT, SGPT, and GGTP
Glomerulonephritis (Bright's disease): The kidneys' filters (glomeruli) become inflamed and scarred, losing their ability to remove wastes and excess water from the blood to make urine. As the kidney damage progresses, symptoms may develop, such as: blood (hematuria) and protein (proteinuria) in the urine; swelling (edema) in the hands, feet, and ankles; and elevated blood pressure. If left untreated, the condition can lead to kidney failure. Treatment aims to slow the progression and prevent complications.	**History of Condition:** • Date of diagnosis? • Details/type of treatment? • Dates and results of renal biopsy? • Results of latest urinalysis? • Past and recent kidney function test results—BUN, creatinine, 24-hr. urine protein • Any other medical conditions?

Heart Enlargement/Cardiomegaly: Enlargement can be diagnosed on examination, by X-ray, suggested on a resting EKG, or through "the Gold Standard," an echocardiogram (ultrasound of the heart). The enlargement can be a concentric or asymmetric thickening (hypertrophy) of the left ventricular wall or dilation of a heart chamber (atria or ventricles) Some causes of heart enlargement: • Arrhythmia • Cardiomyopathy • Congenital heart disease • Hypertension • Obesity • Pericardial effusion • Pulmonary hypertension • Sleep apnea • Valvular heart disease **Normal Ranges on Echocardiogram:** Left atrial dimension (LA): 1.9–4.0 cm Left ventricular dimension at end-diastole (LVED): 3.7–5.6 cm Right ventricular dimension at end-diastole (RVED): 0.7–2.8 cm Interventricular septum (IVS) thickness at enddiastole: 0.6–1.2 cm LV posterior wall (LVPW) thickness at end-diastole: 0.6–1.2 cm IVS/LVPW ratio: < 1.3 cm Aortic root dimension: 2.0–4.0 cm	**History of Condition:** • Date of diagnosis? • Type and severity? • Results of any Echocardiograms? • Any other medical conditions? **Current Condition:** • Current symptoms? • Restrictions on activities? • Does the client smoke?
Heart Murmur	See Valvular Heart Disease
Hemochromatosis (Bronzed Diabetes): Hemochromatosis is a condition that develops when too much iron builds up in the body, resulting in damage to tissues and eventually organ dysfunction. Diagnosis is made through blood tests of iron, transferrin, and ferritin levels. Excess iron can lead to: • Bronze pigmentation of the skin • Cirrhosis • Cardiomyopathy • Liver failure • Liver cancer Hemochromatosis is treated by getting rid of extra iron in the body through regular blood loss (phlebotomy) or use of chelating agents that gather up excess iron and remove it through the urine. If hemochromatosis is treated early, most people have a normal life expectancy.	**History of Condition:** • Date of diagnosis? • Severity of liver disease? • Results of any liver biopsies or ultrasounds? • Type and dates of treatments? • Past and recent liver function test results—SGOT, SGPT, GGTP • Past and recent serum transferring saturation, ferritin level, serum iron
Hepatitis	See Liver Disorders

Hypertension: Age, gender, genetics, obesity, salt consumption, psychological stress, trauma, pregnancy, kidney disease, endocrine disorders, and tumors can affect blood pressure levels. When BP levels are elevated over time, the risk for developing coronary artery disease, cerebrovascular accidents (CVA, stroke), kidney disorders, and congestive heart failure (CHF) increases. The risk of death from hypertension is further increased when combined with other coronary risk factors such as build, smoking, diabetes, family history, and elevated lipids (cholesterol and triglycerides).	**History of Condition:** • Date of diagnosis? • Medications: type and dosage? • Compliant with treatment and visits to their physician? • Degree of control—Current BP levels and readings for the past 2 •years? • Any other medical conditions? • Normal results on EKGs, stress tests, perfusion studies, and echocardiograms?
Kidney Disease: Chronic kidney disease (CKD) is a condition that occurs when the kidneys lose their ability to remove waste or maintain the proper fluid and chemical balances in the body.	**History of Condition:** • Type of kidney disease? • Date of diagnosis? • Results of biopsies/ultrasounds? • Type and dates of treatments? • Kidney function test results: BUN, creatinine, 24-hr. urine protein • Blood pressure levels controlled?
Kidney Transplant: Surgical replacement of diseased kidneys with a healthy (donor) kidney. There are two types of donors. • Living donors—a family member (living related donor [LRD]) or a spouse or close friend (living unrelated donor [LURD]). Transplants using kidney of first-degree relative (father, mother, brother, sister) are most successful. • • Cadaver donor: If there are no compatible living related or unrelated kidney donors, transplant patients are placed on a waiting list to receive a kidney from a person who has recently died (cadaver kidney). To reduce the likelihood of rejection and ensure the donor kidney matches the patient's tissue blood type, blood tests are done prior to transplant.	**History of Condition:** • Date of transplant? • What condition led to transplant? • Source of donated kidney? • Signs of rejection or infection with transplanted kidney? • Type of immunosuppressive therapy used? • Results of current kidney function tests? (BUN, creatinine, 24-hr. urine protein)
Liver disorders: Liver disease can include the build-up of fat (fatty liver), inflammation from a variety of causes (hepatitis), viral infection (viral hepatitis), scarring/fibrosis, and cell damage (cirrhosis).	**History of Condition:** • Date of diagnosis? • Type and severity of liver disease? • Liver biopsies/ultrasound results? • Type and dates of treatments? • Recovered? • Past and recent liver function test results—SGOT, SGPT, GGTP • Hepatitis cases: viral load? • Current and prior alcohol use—type, quantity, and frequency?

Lupus: Systemic lupus erythematosus (SLE) is an autoimmune disease, meaning that the immune system turns against the body it is designed to protect. Lupus can affect many parts of the body, including the joints, skin, kidneys, heart, lungs, blood vessels, blood levels, and central nervous system. Some of the most common symptoms are fatigue, swollen or painful joints (arthritis), unexplained fever, and skin rashes.	**History of Condition:** • Date of diagnosis? • Dates of flare-ups and remission? • What are primary symptoms and any complications? • Medication: type and dosage? • Any physical limitations/disability? • Any other medical conditions? Kidney function test results? BUN, creatinine, 24-hr. urine protein
Mitral Valve Prolapse	See Valvular Heart Disease
Multiple Sclerosis: Degenerative disease of the central nervous system, in which hardening of tissue occurs throughout the brain and/or spinal cord. Symptoms include visual and sensory disturbances, weakness, lack of coordination, tremor, and spastic paraplegia.	**History of Condition:** • Date of diagnosis? • Suspected or definite diagnosis? • What are primary symptoms? • Dates and frequency of attacks and remission? • Medication: type and dosage? • Is client's condition stable? • Is client ambulatory and independent? • Using braces, walker, or wheelchair? • Any problems with kidneys or bladder? • Currently employed or disabled?
Muscular Dystrophy: Inherited, progressive muscular weakness due to irreversible muscle fiber degeneration.	**History of Condition:** • Date of diagnosis? • Type of muscular dystrophy? • Degree of physical impairment and rate of progression? • Type of treatment? • Medication: type and dosage? • Any other medical conditions?
Osteopenia and Osteoporosis: Osteopenia and osteoporosis refers to lower bone mineral density (BMD—bone mass and strength) that results when the rate of bone destruction exceeds the rate of bone formation. Osteoporosis does not result in death, but hip fractures can lead to pulmonary emboli and impaired mobility. Vertebral fractures can lead to back pain, hunchback, impaired	**History of Condition:** • Date of diagnosis? • Results of BMD, X-ray, MRI, and CT scans? • Stable? Rate of progression? • Medication: type and dosage? • Any fractures, mobility problems, spinal curvature, or disability?
Paraplegia, Quadriplegia: Paralysis of legs, or arms and legs.	**History of Condition:** • Date of onset? • Cause of paralysis? • Any respiratory problems? • Any bowel or bladder issues?
Parkinson's Disease: Neurological disorder characterized by tremor, rigidity, and loss of motor control. The cause is unknown, but it can result from toxins, ischemia, infection, or trauma.	**History of Condition:** • Medication: type and dosage? • Onset date of symptoms? • Severity and degree of physical impairment? • Rate of progression? • Living independently? • Any assistance required? • Medication: type and dosage? • Any other medical conditions? • Impaired judgment?

Peptic Ulcer Disease: Sores in the inner lining of the stomach (gastric) or upper small intestine (duodenal) develop when the stomach's digestive juices irritate and damage the tissue. Infection with Helicobacter pylori (H. pylori) promotes ulceration and inflammation.	**History of Condition:** • Date of diagnosis? • Medication: type and dosage? • Any blood in the stool? • Amount of any weight loss? • Any anemia—hemoglobin level? • Any difficulty swallowing (dysphagia) or jaundice? • Any obstruction? • Dates of any surgeries? • Current and prior smoking history? • Current and prior alcohol use—type, quantity, and frequency?
Peripheral Vascular Disease (PVD): Atherosclerosis of the aorta and peripheral arteries. Peripheral vascular disease is most common in the vessels in the legs but can be present in the abdominal aorta, iliac, and renal arteries. Complications include skin ulcers and renal failure.	**History of Condition:** • Date of diagnosis? • Any surgeries? • Medication: type and dosage? • Any other conditions such as hypertension, elevated lipids? • Claudication (exercise-induced pain in legs)? • Normal kidney function? • Smoking history?
Polycystic Kidney Disease: Enlargement of the kidneys due to the formation of bilateral multiple cysts. Hereditary condition with no known cure, although symptoms can be treated.	**History of Condition:** • Date of diagnosis? • Details/type of treatment? • Results of kidney function tests (BUN, serum creatinine tests, 24-hr. urine)? • BP levels controlled?
Rheumatoid Arthritis: A chronic, inflammatory disease of unknown cause. The characteristic feature is joint deformity and persistent inflammation of the lining of the joints. Severity of the disease ranges from mild to a relentless, progressive polyarthritis with severe functional impairment. Some toxic forms of treatment can result in systemic complications.	**History of Condition:** • Date of diagnosis? • Medication: type and dosage? • Any steroid or immunosuppressant use? • Any complications from medication used? • Rheumatoid factor level and sedimentation rate? • Details re: any physical limitations or disability? • Any other medical conditions? • Any anemia—hemoglobin level?
Schizophrenia/Paranoia: Group of severe mental/emotional disorders, often involving delusions, hallucinations, and bizarre behavior.	**History of Condition:** • Date of diagnosis? • How severe is disorder? • Type of treatment? • Hospitalization required? • Medication: type and dosage? • Client capable of managing own affairs? • Is client employed? • Taking drug therapy? • Type and dosage?

Sleep Apnea: Cessation of breathing for at least ten seconds during sleep. Apnea Index is the number of apnea episodes per hour. Hypopnea is 30 to 50 percent impaired airflow lasting ten seconds or more. Respiratory distress index (RDI) is the total of apneas and hypopneas. The term "sleep apnea" is used to describe a wide spectrum of complaints from loud snoring to periods of respiratory arrest long enough to lead to hypoxemia. Usually caused by upper-airway obstruction (obstructive) or loss of brain center drive (central).	**History of Condition:** • Date of diagnosis? • Type and severity? • Type of treatment received? • Is client compliant with treatment? • Results of pre- and posttreatment sleep studies (polysomnograms): apnea index, hypopnea index, O2 saturation? • Is client overweight? • Any daytime sleepiness? • Any motor vehicle incidents? • Heart condition or arrhythmias? • Blood abnormalities (hemoglobin) • Use of alcohol or other sedatives?
Stroke	See Cerebrovascular Disease
Suicide Attempt	**History of Condition:** • Date of attempt? • Reason for attempt? • Multiple attempts? • Has client been hospitalized? • Medication: type and dosage? • Is client leading a normal life?
Transient Ischemic Attack (TIA)	See Cerebrovascular Disease
Ulcerative Colitis: An inflammation of the mucosal layer of the wall of the large bowel.	**History of Condition:** • Date of diagnosis? • Frequency and severity of attacks? • Date of last attack? Treatment? • Hospitalization or surgery? • Medication: type and dosage? • Ongoing symptoms? • Underweight or anemic? • Any other medical conditions?

Valvular Heart Disease:

Heart murmurs are classified as **functional** murmurs and **organic** murmurs based on the timing, loudness, duration, and location.

Functional Murmurs (also known as **physiologic** or **innocent** murmurs) are:

- Always systolic
- Soft (Grade 1 or 2)
- Non-radiating
- Present and unchanged for long periods

Organic Murmurs are:

- All diastolic murmurs
- Deformed heart valve caused by congenital heart disease, rheumatic heart disease, or atherosclerotic heart disease.
- Variety of heart murmurs caused by blood flow through a damaged heart or valve:
    - Aortic insufficiency
    - Aortic stenosis
    - Mitral insufficiency
    - Mitral stenosis
    - Mitral valve prolapse
    - Pulmonary insufficiency
    - Pulmonary stenosis
    - Tricuspid insufficiency
    - Tricuspid stenosis

History of Condition:

- Date of diagnosis?
- Type and severity of murmur?
- More than one murmur?

Treatment:

- Results of any echocardiograms?
- Describe treatment
- Dates and type of any surgeries?

Related Issues:

- Any cardiac, arrhythmia, or congestive heart failure history?
- Any heart enlargement?
- History of rheumatic fever?

Current Condition:

- Current symptoms?
- Restrictions on activities?
- Does the client smoke?

COMMON NON-MEDICAL IMPAIRMENTS SUMMARY

NON-MEDICAL ISSUE:	UNDERWRITING FACTORS
Aviation—Flying for pleasure or business • Commercial aviation • Private aviation • Military aviation • Student pilot	**History:** • Type of License? • Total flying experience? • Total hrs flown p/yr x past 3 yrs? • Instrument (IFR), Visual Flight Rating I(VFR), Airline Transport Pilot (ATP)? • Type of aircraft used? • Any specialized flying? • Any flights outside the USA? • Scheduled or non-scheduled? **Related Issues:** • Any motor vehicle violations? • Any citations? • Full coverage or exclusion rider desired?
Driving History	**History:** • Number, dates, and types of infractions (speeding tickets, •accidents, reckless driving, etc.)? • Dates of any DUI or DWI? • Suspensions or revocations? • Driver's class after any violation? **Related Issues:** • Current/prior alcohol/drug use? • Treatment for substance abuse? • Any other medical problems?

Foreign Travel/Foreign Residency	**History:**
	• US citizen?
	• Country of origin and citizenship?
	• Green card?
	• Years in USA?
	• Type of visa? Expiration date?
	• Own property in the USA?
	• Travel outside USA in past 24 months and future plans:
	  • Cities and counties?
	  • Purpose of visit?
	  • Frequency and duration?

Motor Vehicle Racing	**History:** • Total experience? • Type of course? • Type of vehicle? • Size of engine, type of fuel? • Average and top speed achieved? • Frequency of races? • Name of organization that sanctions the racing?

Rock/Mountain Climbing	**History:** • Locations and frequency of climbs in the last 2 years? • Type of terrain (i.e., established trails, rock, etc.)? • Any climbs outside the US? • Ice or glacier climbing? • Grade of climbs? • Maximum altitude? • Any specialized climbing equipment used? • Any motor vehicle violations?
Scuba Diving	**History:** • Total experience? • Any certification? • Dive alone or with a group? • Member in any clubs? • Frequency and depths of dives? • Location of dives (ocean, lakes, wrecks, rescue, ice, caves)? **Related Issues:** • Any medical conditions? • Driving history?

NAILBA

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SUPPLEMENTAL FORMS SECTION

Authorization to Release Results

Date: MONTH DAY 20 99

To: (Carrier Name and Address)

From: (Client Name and Address)

RE: File Number:
Date of Birth: MONTH DAY 19 99
Social Security #:

Please fax my insurance exam, lab results (blood and urinalysis), and resting EKG to me at:

Fax:

Phone:

Thank you for your prompt attention to my request.

Sincerely,

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 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. 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

(Accurate) Name of Medication	Dosage	Reason

7. Please list current medications (accurate name, dosage, and 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 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. 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 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 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 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 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 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 first diagnosis: _____

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

3. Are there any symptoms with the irregular heart beat?

☐ Black-out ☐ Dizziness (light-headedness)/faint feeling

☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:

☐ ECG _____

☐ Stress test _____

☐ Echocardiogram _____

☐ Holter monitor _____

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

(Accurate) Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:

☐ Coronary heart disease ☐ Alcohol

☐ Thyroid disease ☐ Cardiomyopathy

☐ Mitral valve disease ☐ Unknown

☐ Other, give details _____

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

_____

_____

_____

AVOCATIONS

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?

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? ☐ Yes ☐ No Are you a licensed pilot? ☐ Yes ☐ No

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:** _____

☐ 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?

☐ 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)

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 UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

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

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

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please 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): _____

_____

_____

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

☐ Endoscopic resection only
☐ Endoscopic resection and chemotherapy instilled in the bladder
☐ Radical cystectomy (removal of the bladder)
☐ Radiation therapy

☐ Systemic chemotherapy

3. What stage was the cancer?

☐ Tis ☐ T☐ 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) _____

_____

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

_____

8. Has there been any evidence of recurrence? (if yes, 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 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. 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 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

_____

_____

_____

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

☐ Surgery ☐ Radiation ☐ Chemotherapy

3. What stage was the cancer?

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

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 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 was the pretreatment PSA? _____

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

☐ Observation only ☐ TURP (transurethral prostatectomy) ☐ Radical prostatectomy

☐ Radiation therapy (seed implant or external beam radiation

4. What is date and result of the most current PSA test? _____

_____

5. What was the Gleason score? _____

6. What stage was the cancer?

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

7. Is there a family history of cancer? ☐ No ☐ Yes

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

CANCER—SKIN

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(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

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

_____

_____

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 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(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 1 ☐ 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 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. At what age was it first diagnosed? _____

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

_____

_____

3. Is client on any medications now? (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 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 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 major health issues (heart disease, etc.)? (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 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 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 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. 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 surgery Date: _____

4. Has client had any of the following?:

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

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

CORONARY BYBASS

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. 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 provide 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 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 first diagnosis: _____

2. Blood in stools? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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

_____

2. What evaluation was done? Please give date and results.

☐ MRI, CT Date: _____ / _____ / _____ ☐ Urine Test Date: _____ / _____ / _____

☐ Blood 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 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. 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 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. List the diagnosis: _____

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

3. Has client been hospitalized for psychiatric treatment? ☐ No ☐ Yes; plesase give dates and lengths of stay.

_____

_____

4. Does client have a history of any of the following associated conditions? Please check all that apply. (Additional questionnaires may be required)

☐ Personality disorder
☐ Psychotic disorder
☐ Suicidal thought/attempt
☐ Substance abuse (alcohol or drugs) (complete questionnaire)
☐ Other psychiatric disorder _____

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

_____

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

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

6. 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 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 first diagnosed: _____

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

   When was the last visit? _____

3. The client's diabetes is controlled by:

☐ Diet alone

☐ Oral medication (medication and doses) _____

☐ Insulin (amount and units/day) _____

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

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

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

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

☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated lipids

☐ Overweight ☐ Neuropathy ☐ Kidney disease

☐ Retinopathy ☐ Abnormal ECG ☐ Hypertension

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

DOWN SYNDROME / RETARDATION

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 applicant's IQ? _____

2. Is applicant self-supporting? ☐ 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

_____

_____

RETARDATION

1. At what age did applicant become mentally retarded? _____

2. Is the retardation 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 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. 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 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 the initial treatment or diagnosis? _____

2. What is client's: ☐ Martial status: _____ ☐ Occupation: _____
☐ Length of employment: _____

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

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

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

9. What is client's current level of alcohol consumption? _____

10. Is client taking any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

EATING DISORDERS

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

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

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

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

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

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please give the diagnosis: ☐ Anorexia nervosa ☐ Bulimia nervosa

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

_____

3. Please note client's current _____ height _____ weight

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

_____

_____

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

_____

_____

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

☐ Substance abuse (alcohol or drugs) Personality disorder

☐ Psychotic disorder Suicidal thought/attempt

☐ Depression Anxiety disorder

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

EMPHYSEMA

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

_____

_____

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 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. When was the condition first diagnosed? _____

2. Have any of the following symptoms occurred?

☐ Chest discomforto
☐ Fainting spells or dizziness
☐ Shortness of breath
☐ Palpitations (irregular heart beat)

3. Please check if your client has had any of the following:

Chest X-ray: ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Exercise treadmill or thallium ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Resting or exercise echocardiogram ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
MUGA ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal
Cardiac catheterization ☐ No ☐ Yes, Normal / ☐ Yes, Abnormal

4. Is there a history of any heart disease (problems with valves, coronary artery disease, cardiomyopathy, etc.)?

☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

EPILEPSY

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 first diagnosis: _____

2. Indicate the type of seizure:

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

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

_____

4. Has client been hospitalized for treatment of epilepsy? (give details)

☐ No ☐ Yes; please give details _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

6. What is client's occupation? _____

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

_____

_____

GENERAL USE QUESTIONNAIRE

(IF THERE IS NOT A SPECIFIC IMPAIRMENT QUESTIONNAIRE, THEN PLEASE COMPLETE THIS FORM)

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. List impairment: (Give as much detail as possible, include when the condition was diagnosed, how it was contracted, and current prognosis)

_____

_____

_____

2. Has there been any treatment? ☐ No ☐ Yes; (Please provide start and end dates, name of treatment.)

_____

_____

_____

_____

3. Is client on any medications now? (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

_____

_____

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 UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

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

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

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please 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 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 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 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. 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 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 was the cause of heart failure? _____

2. When was the diagnosis made? _____

3. Has client had surgical heart repair? ☐ No ☐ Yes; please give details

_____

_____

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 an angiogram, echocardiogram, stress test, or heart scan been done? ☐ No ☐ Yes; please give details

_____

_____

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 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 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 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 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 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 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 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 diagnosis: _____

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

3. Was there a thromboembolic event?
☐ MI ☐ CVA ☐ DVT ☐ PE ☐ 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 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 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 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 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?

☐ Yes; normal Date: _____ ☐ Yes; abnormal Date: _____
☐ No

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 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 first diagnosed: _____

2. Is the irregular heatbeat due to (check all that apply):

☐ Premature supraventricular atrial beats (PACs)
☐ Premature ventricular beats (PVCs)
☐ Multifocal
☐ Bigeminy or trigeminy
☐ Ventricular tachycardia

3. Are there any symptoms with the irregular heartbeat?

☐ Black-out ☐ Dizziness (lightheadedness)/faint feeling ☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? (If so, please give date and results)

☐ ECG Date: _____ _____
☐ Stress test Date: _____ _____
☐ Echocardiogram Date: _____ _____
☐ Holter monitor Date: _____ _____

5. The cause of the irregular heart beat is due to: ☐ Heart disease ☐ Alcohol ☐ Thyroid disease ☐ Unknown or other _____

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

_____

_____

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 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 first diagnosed: _____

2. Please check if any of these conditions are present (complete questionnaire for each condition checked):

☐ Diabetes
☐ Polycystic kidney disease
☐ Glomerulonephritis
☐ Nephrosclerosis
☐ Systemic lupus erythematosus
☐ Other: _____

3. Give most recent results of kidney function tests:

☐ BUN _____
☐ Serum creatinine _____
☐ Urinalysis _____

4. Have any of the following occurred (check all that apply):

☐ Frequent infection
☐ High blood pressure
☐ Cardiovascular disease (complete questionnaire for this condition)

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

KIDNEY TRANSPLANT

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

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

☐ Cardiovascular 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 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 is the current stage of the leukemia?

☐ Stage 0 ☐ Stage 1 ☐ 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 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: _____

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

2. 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: _____ _____

3. Have these results been

☐ Increasing
☐ Decreasing
☐ Fluctuating up and down
☐ Stable
☐ Unknown

4. Does client drink alcohol? (answer all that apply)

☐ No ☐ Yes; please note amount and frequency _____

☐ Drinking pattern changed recently _____

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

_____

_____

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 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. 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; please give details

_____

_____

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

_____

LUPUS

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. Type of lupus diagnosed?:
☐ Systemic lupus erythematosus (SLE)
☐ Discord lupus
☐ Drug-induced SLE

3. Please note if the lupus is:

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

☐ currently present

4. Check if client has had any of the following:
☐ Low blood counts ☐ Neurologic disorder
☐ Lung involvement (pleuritis) ☐ Heart involvement (pericarditis)
☐ Proteinuria ☐ Renal insufficiency or failure
☐ High blood pressure

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

_____

_____

6. What type of treatment has client had? _____

7. When was treatment terminated? _____

8. Have steroids ever been prescribed? ☐ No ☐ Yes

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

_____

_____

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 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. 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 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. 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 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. How long has this abnormality been present? _____

2. Please check the type(s) of valve disorder present:

☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral valve prolapse

3. Have any of the following occurred?

Chest pain ☐ No ☐ Yes

Trouble breathing ☐ No ☐ Yes

Heart failure ☐ No ☐ Yes

Palpitations ☐ No ☐ Yes

Atrial fibrillation/flutter ☐ No ☐ Yes

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

_____

_____

5. Have additional studies been completed? (check all that apply)

☐ Echocardiogram Date: _____

☐ Cardiac catheterization Date: _____

☐ None

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

MITRAL VALVE PROLAPSE

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

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

6. Is client receiving any treatment? ☐ No ☐ Yes, What type? _____

9. When did client last see doctor for this condition? _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

PACEMAKER

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 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 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. List the date when first diagnosed: _____

2. What type of pancreatic disorder was diagnosed?

☐ Cyst, Pseudocyst ☐ Abscess ☐ Pancreatitis ☐ Stone

☐ Other; please give details _____

3. Was client incapacitated from work due to the pancreatic disorder? ☐ No ☐ Yes; when and for how long

_____

_____

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 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. 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 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 disability occured? _____

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

_____

_____

3. What parts of the body are affected?

_____

_____

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

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

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

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

_____

_____

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 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 first diagnosed: _____

2. Please note the functional stage of the client currently:

☐ Stage I unilateral involvement
☐ Stage II bilateral involvement but normal stance
☐ Stage II 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

_____

_____

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

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

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

_____

_____

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 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 diagnosis? _____

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

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

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

_____

_____

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

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

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

PHEOCHROMOCYTOMA

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 diagnosis? _____

☐ Benign vs. ☐ Malignant

☐ Single vs. ☐ Multiple

2. What evaluation was done? Please give date and results.

☐ MRI, CT Date: _____ _____

☐ Urine Test Date: _____ _____

☐ Blood Test Date: _____ _____

3. Has your client had surgery to remove a pheochromocytoma? ☐ No ☐ Yes; please give details

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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 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. 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 _____

Red blood cell (RBC) _____

White blood cell (WBC) _____

Protein/creatinine ratio _____

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 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 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 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 when first diagnosed: _____

2. If any of the following have been done, please give details and result(s):

☐ Bladder catheterization _____

☐ Prostate biopsy _____

☐ Prostate ultrasound _____

☐ TURP (transurethral prostatectomy) _____

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

Date: _____ _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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 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. 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 cells (WBCs) Date: _____ _____
   - d. Protein/creatinine ratio Date: _____ _____
4. Give the dates and results of the most recent kidney function tests:
   - a. BUN Date: _____ _____
   - b. 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

_____

_____

PSA—ELEVATED

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. 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 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 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

8. Give results of the most recent pulmonary function tests:

FVC _____

FEV1 _____

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

_____

_____

10. Is client taking any medication, including inhalers? (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

_____

_____

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 UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

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

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

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please 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
☐ Reyaud's disease ☐ Trouble swallowing

5. Please list functional ability:

☐ Fully active
☐ Sedentary
☐ Uses walker, cane, etc.
☐ Uses wheelchair

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

_____

_____

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 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 first diagnosis: _____

1. When did client have the first and last attack? _____

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

3. What is the frequency of the attacks? _____

_____

4. What type of treatment is indicated? _____

_____

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

_____

_____\

6. What is client's occupation?

_____

7. Is client taking any medication, including inhalers? (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

_____

_____

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 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 diagnosis: _____

2. What type of sickle cell anemia does client have?

☐ Sickle cell (SS)
☐ Sickle cell (SC)
☐ Sickle cell trait (SA)
☐ Hemoglobin C

3. Is there a history of complications? ☐ No ☐ Yes; please check those that apply and give the date of the last episode.

☐ Painful crisis Date: _____
☐ Aaseptic necrosis of bones Date: _____
☐ Leg ulcers Date: _____
☐ Lung scarring Date: _____
☐ Thrombosis Date: _____
☐ Enlarged heart Date: _____
☐ Other: _____ Date: _____

4. What is the current hemoglobin? _____

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

(Accurate) Name of Medication	Dosage	Reason

6. 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 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 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 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 diagnosis: _____

2. At what spinal cord level was the injury? (list specific vertebrae, if available)

☐ Cervical spine _____

☐ Thoracic spine _____

☐ Lumbrosacral spine _____

3. Note current level of function:

☐ Incomplete paraplegia ☐ Complete paraplegia

☐ Incomplete quadriplegia ☐ Complete quadriplegia

4. Have any of the following occurred? (check all that apply)

☐ Pneumonia

☐ Skin ulcers

☐ Urinary tract infection

☐ Kidney impairment

☐ Depression

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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. 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 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(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: Date: _____ _____

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 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 diagnosis: _____

2. Note the type of treatment:

☐ Coumadin
☐ Aspirin
☐ Heparin
☐ Hospitalization Date: _____

3. Was there a Thromboembolic event?

☐ MI
☐ DVT
☐ CVA
☐ PE
☐ Other _____
☐ None

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

_____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

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 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 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

6. 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 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. 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

_____

_____

VALVULAR HEART SURGERY

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. When was the surgery completed? _____

2. Please note type of valve surgery:

☐ Valve replacement ☐ Valvuloplasty

☐ Commissurotomy ☐ Other _____

3. Please check the type (s) of valve disorder:

☐ Aortic stenosis ☐ Mitral stenosis ☐ Mitral valve prolapse

☐ Aortic insufficiency ☐ Mitral insufficiency

4. Please note type of valve used if replaced:

☐ Prosthetic (mechanical) ☐ Tissue (porcine or pig)

5. Have any of the following occurred?

☐ Chest pain ☐ Heart failure ☐ Palpitations ☐ Dizziness/fainting ☐ Trouble breathing

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

_____

_____

7. Is client taking any medication, including inhalers? (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

_____

_____

Authorization for Release of Information – *SAMPLE ONLY*

NOTE: CONTACT YOUR AGENCY FOR AGENCY APPROVED HIPAA FORM

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize YOUR AGENCY HERE and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to YOUR AGENCY HERE . I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as YOUR AGENCY HERE and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, YOUR AGENCY HERE may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

PROPOSED INSURED'S NAME

PROPOSED INSURED'S SIGNATURE

SIGNED AND DATED ON AT (CITY, STATE, ZIP CODE)

AGENT/ WITNESS

CARRIERS TO WHOM CARRIERS MAY RELEASE INFORMATION

ACKNOWLEDGEMENTS

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