

Agent Information

Agent Name: _____

Agent Phone Number: _____

Agent Email Address: _____

Proposed Policy

Monthly Benefit: _____

Benefit Duration: _____

Riders Requested: _____

Resident State: _____

Partnership: _____

Yes No

Client Information

Client's Name: _____

Tobacco User: Yes No

State: _____

If so, please indicate the type and frequency. If quit, indicate last use.

Male Female

DOB: ___ / ___ / ___ Height: _____ Weight: _____

Spouse or Significant other? Yes No

Medical Questions

Have you ever been diagnosed with or treated for one of these conditions? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Diabetes requiring Insulin | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Amputation-Due to Disease |
| <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Double Heart Valve Replacement |
| <input type="checkbox"/> Stroke or Transient Ischemic Attack (TIA) | <input type="checkbox"/> Organ or Bone Marrow Transplants |
| <input type="checkbox"/> Alzheimer's Disease, Lewy Body Disease, or Dementia | <input type="checkbox"/> Kidney Disease or Polycystic Kidney Disease |
| <input type="checkbox"/> Psychosis or Schizophrenia | <input type="checkbox"/> Cirrhosis of the Liver |
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Hepatitis B, C, D or E |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) or Myasthenia Gravis | <input type="checkbox"/> Hemachromatosis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Metastatic Cancer |
| <input type="checkbox"/> Parkinson's Disease or Parkinsonism | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Post-Polio Syndrome | <input type="checkbox"/> Brain or Spinal Cord Tumors |
| <input type="checkbox"/> Demyelinating Disease | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Lupus (SLE) | <input type="checkbox"/> Neurological Conditions affecting the brain or spinal cord |
| <input type="checkbox"/> Mixed Connective Tissue Disease | <input type="checkbox"/> Muscular Conditions Causing Functional Limits |

Medications Check here if you DO NOT TAKE ANY MEDICATIONS

Record all medications you currently take including **prescription medications** and any **over the counter drugs**.

Name of Drug	Dosage	Frequency	When Prescribed	Reason for Taking

Have you been prescribed any medications you are not taking?

Yes No If yes - provide details (i.e. name of medication, who prescribed, for what condition, why not taking it: _____

Do you have any surgeries planned or recommended?

Yes No Provide details of Type of Surgery and when it is scheduled: _____

When was the last time you saw your primary physician and why?

Date Last Seen: _____
Reason: _____

List any specialists you have seen in the last 5 years.

Type of Specialist:	Month/Year last seen:	Reason for Visit:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you ever been on disability?

Yes No Provide details: _____

Do you have a handicapped parking tag?

Yes No If yes, why? _____

Have you ever been turned down for any insurance coverage?

Yes No If yes - give type of insurance, date and reason: _____

Cancer History

Type: _____
Date Diagnosed: _____
Treatment: _____

Stage: _____
Grade: _____
Lymph Node Involvement: Yes No
Date of Last Treatment: _____
Any Recurrence? Yes No
If prostate cancer, please include pre-PSA: _____
current PSA: _____
Gleason Score: _____

Heart Disease History

Heart Attack: Yes No
If yes, please provide date(s): _____

Stroke: Yes No
If yes, please provide date(s): _____

TIA: Yes No
If yes, please provide date(s): _____

Bypass Surgery? Yes No
If yes, please provide date(s): _____

Angioplasty? Yes No
If yes, please provide date(s): _____

Pacemaker? Yes No
If yes, please provide date(s): _____

Defibrillator? Yes No
If yes, please provide date(s): _____

Diabetes History

Type I Type II
Date Diagnosed: _____
Medications: _____
A1C: _____
Any Complications (retinopathy, neuropathy, nephropathy): _____

Mental Illness/Depression History

Name of condition: _____
Date Diagnosed: _____
Severity: _____
Treatment: _____

Seeing a psychiatrist/psychologist? _____
Attempted suicide? If yes, date(s): _____
Hospitalization due to depression? Yes No

Lung Disorder History

Type of Disorder (asthma, bronchitis, COPD, emphysema, etc.): _____

Treatment: _____
Severity: _____
Frequency of attacks: _____
Dates of hospitalizations/ER visits: _____

