

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

Agent Name: _____ Agent Phone: _____ Agent Email: _____

CLIENT NAME: _____		Date: _____	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of birth: _____	Height: _____' _____" Weight: _____
Tobacco Use: <input type="checkbox"/> Never used <input type="checkbox"/> Totally stopped		Date stopped: _____	<input type="checkbox"/> Use now Type of nicotine product: _____
Type of Coverage: <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> Survivor		Type of Coverage: <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> 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? <i>If yes, use separate sheet to provide this information, including age of onset and date of death</i>			
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

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