

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

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

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

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

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

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

### FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

### PROPOSED INSURED'S EXISTING INSURANCE

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

1. Date of 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

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