

**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?

- Date first diagnosed: \_\_\_\_\_
- 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: \_\_\_\_\_
- Give most recent results of kidney function tests:
  - BUN \_\_\_\_\_
  - Serum creatinine \_\_\_\_\_
  - Urinalysis \_\_\_\_\_
- Have any of the following occurred (check all that apply):
  - Frequent infection
  - High blood pressure
  - Cardiovascular disease (complete questionnaire for this condition)
- 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

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