

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

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 _____ Date: _____

Red blood cell (RBC) _____ Date: _____

White blood cell (WBC) _____ Date: _____

Protein/creatinine ratio _____ Date: _____

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

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

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 when first diagnosed: _____
- If any of the following have been done, please give details and result(s):
 - Bladder catheterization _____
 - Prostate biopsy _____
 - Prostate ultrasound _____
 - TURP (transurethral prostatectomy) _____
- 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

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 cell (WBC) _____ Date: _____

d. Protein/creatinine ratio _____ Date: _____

4. Give the dates and results of the most recent kidney function tests:

BUN _____ Date: _____

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

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

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



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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

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
7. Give results of the most recent pulmonary function tests:
 FVC _____
 FEV1 _____
8. Has there been any evidence of recurrence/progression? 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



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

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
- Reynaud's disease Trouble swallowing

4. Please list functional ability:

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

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

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

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. When did client have the first and last attack? _____
3. Are the attacks grand mal or petit mal in character?
4. What is the frequency of the attacks?

5. What type of treatment is indicated?

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

7. What is client's occupation? _____
8. Is client taking any medication, including inhalers? (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



SICKLE CELL ANEMIA



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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

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: _____
 - Aseptic 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

7. 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

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

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 of diagnosis: _____
- At what spinal cord level was the injury? (list specific vertebrae, if available)
 - Cervical spine _____
 - Thoracic spine _____
 - Lumbrosacral spine _____

- Note current level of function:
 - Incomplete paraplegia Complete paraplegia
 - Incomplete quadriplegia Complete quadriplegia

- 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

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?

- When and where was the stent put in? _____
- What type of stent was put in? _____
- Why was the stent put in?

- How many vessels were involved? _____
- Has the applicant had an imaged stress test done? No Yes; if yes, when and what were the results?

- What type of follow-up testing has been done and what were the results?

- Was there a heart attack prior to the stent being put in? No Yes
- 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

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

STROKE, TIA



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NAILBA
NAILBA University

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

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: _____

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

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 of diagnosis: _____
- Note the type of treatment:
 - Coumadin
 - Aspirin
 - Heparin
 - Hospitalization Date: _____

- 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



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NAILBA
NAILBA University

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

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

7. 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

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

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



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

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



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,

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 af- filiated 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 Account- ability Act of 1996 (“HIPAA”) concerning me to my Representa- tive 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 with- out 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 in- formation 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 re- fuse 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