

**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. Does client presently consume alcoholic beverages?  No  Yes, If yes, please list

Beer: Quantity \_\_\_\_\_ oz. per  day  week  month (select one)

Wine: Quantity \_\_\_\_\_ oz. per  day  week  month (select one)

Liquor: Quantity \_\_\_\_\_ oz. per  day  week  month (select one)

2. What was the date of initial treatment or diagnosis? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. Were there any relapses from sobriety/abstinence?  No  Yes; please provide details and dates

4. Were there any legal problems (such as DUI) or other?  No  Yes; please provide details and dates

5. Have there been physical complications or additional psychiatric problems?  No  Yes; please provide details and dates, including use of other substances such as marijuana or cocaine

6. Does client currently participate in a group such as Alcoholics Anonymous?  No  Yes

(Accurate) Name of Medication	Dosage	Reason

7. Please list current medications (accurate name, dosage, and reason):

8. What is client's: Marital status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Length of employment: \_\_\_\_\_

9. Are there any other health issues? (additional questionnaires may be required)  No  Yes; please give details