

CANCER QUESTIONNAIRE

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE NO YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

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| <p>1. PLEASE NOTE TYPE OF MALIGNANCY OR CANCER:
 BLADDER
 BREAST
 CERVICAL
 COLON OR RECTAL (<u>COMPLETE QUESTION #4</u>)
 HODGKIN'S DISEASE
 MELANOMA (<u>COMPLETE QUESTION #5</u>)
 PROSTATE (<u>COMPLETE QUESTION #9</u>)
 SKIN (<u>COMPLETE QUESTION #5</u>)
 OTHER _____</p> <p>2. HAS TUMOR OR MALIGNANCY METASTASIZED?
 NO YES, DATE DIAGNOSED: MONTH _____ YEAR _____</p> <p>3. STAGE OF TUMOR OR MALIGNANCY: T ____ N ____ M ____
 (INCLUDE PATHOLOGY REPORT IF AVAILABLE)
 <u>OR:</u> 1 2 2A 2B 3 3A 3B 4 5
 OTHER _____</p> <p>4. <u>FOR COLON OR RECTAL CANCER ONLY</u> - DUKE'S SCALE:
 A1 B1 B2 C1 C2 D</p> <p>5. <u>FOR MELANOMA ONLY</u> - CLARK'S LEVEL:
 I II III IV V</p> | <p>TYPE _____</p> <p>LOCATION ON BODY _____ DEPTH _____</p> <p>6. TYPES OF TREATMENT USED (CHECK ALL THAT APPLY):
 SURGICAL REMOVAL (give details) _____
 CHEMOTHERAPY
 RADIATION THERAPY
 HORMONAL (ORCHIDECTOMY - DES. LUPRON)
 OTHER _____</p> <p>7. DATE OF LAST TREATMENT RECEIVED _____</p> <p>8. HAS THERE BEEN ANY MEDICAL EVIDENCE OF RECURRENT CANCER?
 NO YES, DETAIL DATE AND OCCURRENCE: _____</p> <p>9. <u>FOR PROSTATE CANCER ONLY</u> - STAGE: T ____ N ____ M ____
 <u>OR:</u> A1 A2 B1 B2 C1 C2 D
 GLEASON'S GRADE: _____ (VALUE BETWEEN 2-10)
 RESULTS OF MOST RECENT PSA TEST _____
 PSA RESULTS PRIOR TO TREATMENT _____</p> |
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Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.