

OTHER ILLNESSES 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 _____

1. PLEASE LIST ILLNESS(ES) AND DETAILS – INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE AND/OR AMOUNT OF TREATMENT ON EACH):

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER:

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER:

TYPE/SEVERITY _____

DATE OF DIAGNOSIS: MONTH _____ YEAR _____

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
 SURGERY MEDICATION OTHER: _____

2. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

- 0 TO 6 MONTHS AGO
 6 TO 12 MONTHS AGO
 12 TO 24 MONTHS AGO
 OVER 2 YEARS AGO

3. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):
