



Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of birth: _____

Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(1) *Date of first diagnosis:* _____

(2) *Describe current symptoms:* _____

(3) *Does the proposed insured take any medications or have any been taken in the past?* No Yes; please list in table:

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) *Has any surgery been done?* No Yes; please describe: _____

(5) *Is the proposed insured independent (could live alone, without assistance)?* Yes No; list extent of the disability:

(6) *Is the proposed insured receiving disability payments due to inability to work full time?*
 No Yes; since (date): _____

(7) *Is the proposed insured participating in any kind of experimental treatment program?* No Yes; please describe:

(8) *Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:*

