

PARALYSIS—SIMILAR PHYSICAL DISABILITY

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. Date disability occurred? _____

2. What was the cause (e.g., congenital, injury, polio)?

3. What parts of the body are affected?

4. Does client have limitations in walking, driving, speech or other activities? No Yes

5. Has surgery been performed or planned? No Yes

6. Has client's bowel or bladder function been affected? No Yes

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