

1. What is the desired Face Amount?
2. Type of coverage desired? (Term: 10,15,20,25,30) (Permanent: UL, VUL, SUL)
3. What is the client's date of birth?
4. What is the client's gender?
5. What is the client's height?
6. What is the client's weight in lbs.?
7. Has the client ever used any of the following tobacco products: Cigarettes, Cigars, Pipe, Chewing Tobacco, Nicotine Gum, Nicotine Patch, or any other tobacco product?

If Yes:

A. Which of the following tobacco products has the client EVER used?

1. Cigarettes

If Yes: Does the client currently smoke cigarettes?
How many cigarettes per day? (20/pack)

2. Cigars

If Yes: Does the client currently smoke cigars? (includes celebratory cigars)
How many cigars does the client smoke per year?

3. Pipe

If Yes: Does the client currently smoke the pipe?
How many pipes does the client smoke per year?

4. Chewing Tobacco

If Yes: Does the client currently use chewing tobacco?

5. Nicotine Gum

If Yes: Does the client currently use nicotine gum?

6. Nicotine Patch

If Yes: Does the client currently use the nicotine patch?

7. Any other tobacco products

If Yes: List all other forms, whether they still use and if they still use, the frequency of each form.

B. Will the client generate a current urine sample that is negative for nicotine?

8. Have any of their family members (biological) had an OCCURRENCE of the following conditions: cardiovascular disease, cerebrovascular disease (stroke), diabetes, or cancer?

A. None

B: Father

If Yes: Which of the following conditions did the father have an OCCURRENCE?

1. Cancer (Y or N) If Yes:

a. How old when diagnosed?

b. Did relative die of cancer? (Y or N) If Yes: How old were they when they died?

c. Did the client have any of the following types of cancer?

1. Testicular (Y or N)

2. Prostate (Y or N)

3. Other (Y or N)

If Yes: Please describe the type of cancer the client's father had. Please include any details.

2. Cardiovascular disease (CAD) (Y or N)

If Yes:

a. How old when diagnosed?

b. Did they die of cardiovascular disease? If Yes: How were they when they died?

3. Diabetes (Y or N) If Yes:

a. How old when diagnosed?

b. Did they died of diabetes? If Yes: How were they when they died?

4. Stroke (Y or N) If Yes:

a. How old when diagnosed?

b. Did they died of stroke? If Yes: How were they when they died?

5. Other (Y or N)

C: Mother

If Yes: Which of the following conditions did the mother have an OCCURRENCE?

1. Cancer (Y or N) If Yes:

a. How old when diagnosed?

b. Did relative die of cancer? (Y or N) If Yes: How old were they when they died?

c. Did the client have any of the following types of cancer?

1. Breast Cancer (Y or N)

2. Cervical Cancer (Y or N)

3. Endometrial Cancer (Y or N)

4. Fallopian Tube Cancer (Y or N)

5. Ovarian Cancer (Y or N)

6. Vaginal Cancer (Y or N)

7. Vulvar Cancer (Y or N)

8. Other (Y or N) If Yes: Please describe the type of cancer the client's mother had. Please include any details.

2. Cardiovascular disease (CAD) (Y or N) If Yes:

- a. How old when diagnosed?
- b. Did they died of cardiovascular disease? If Yes: How were they when they died?

3. Diabetes (Y or N) If Yes:

- a. How old when diagnosed?
- b. Did they died of diabetes? If Yes: How were they when they died?

4. Stroke (Y or N) If Yes:

- a. How old when diagnosed?
- b. Did they died of stroke? If Yes: How were they when they died?

5. Other (Y or N)

D: Brother (Y or N)

If Yes: Which of the following conditions did the father have an OCCURRENCE?

1. Cancer (Y or N) If Yes:

- a. How old when diagnosed?
- b. Did relative die of cancer? (Y or N) If Yes: How old were they when they died?
- c. Did the client have any of the following types of cancer?
 - 1. Testicular (Y or N)
 - 2. Prostate (Y or N)
 - 3. Other (Y or N) If Yes: Please describe the type of cancer the client's brother had. Please include any details.

2. Cardiovascular disease (CAD) (Y or N) If Yes:

- a. How old when diagnosed?
- b. Did they died of cardiovascular disease? If Yes: How were they when they died?

3. Diabetes (Y or N) If Yes:

- a. How old when diagnosed?

b. Did they died of diabetes? If Yes: How were they when they died?

4. Stroke (Y or N) If Yes:

a. How old when diagnosed?

b. Did they died of stroke? If Yes: How were they when they died?

5. Other (Y or N)

E: Sister (Y or N)

If Yes: Which of the following conditions did the mother have an OCCURRENCE?

1. Cancer (Y or N) If Yes:

a. How old when diagnosed?

b. Did relative die of cancer? (Y or N) If Yes: How old were they when they died?

c. Did the client have any of the following types of cancer?

1. Breast Cancer (Y or N)

2. Cervical Cancer (Y or N)

3. Endometrial Cancer (Y or N)

4. Fallopian Tube Cancer (Y or N)

5. Ovarian Cancer (Y or N)

6. Vaginal Cancer (Y or N)

7. Vulvar Cancer (Y or N)

8. Other (Y or N) If Yes: Please describe the type of cancer the client's sister had. Please include any details.

2. Cardiovascular disease (CAD) (Y or N) If Yes:

a. How old when diagnosed?

b. Did they die of cardiovascular disease? If Yes: How were they when they died?

3. Diabetes (Y or N) If Yes:

a. How old when diagnosed?

b. Did they died of diabetes? If Yes: How were they when they died?

4. Stroke (Y or N) If Yes:

a. How old when diagnosed?

b. Did they died of stroke? If Yes: How were they when they died?

5. Other (Y or N)

9. Has the client EVER been treated (medications) for cholesterol?

If Yes:

A. Is the client currently being treated for cholesterol?

If Yes:

1. When did the client start to control their cholesterol at their CURRENT levels with treatment?

2. Please list the names of any cholesterol medications. Please include the dosage and frequency of each.

If No:

1. When did the client stop receiving treatment for choletserol?

10. What is the client's total cholesterol? (example: 210)

11. What is the client's cholesterol ratio? (example: 4.5)

12. Has the client EVER been treated (medications) for blood pressure?

If Yes:

A. Is the client currently being treated for blood pressure?

If Yes:

1. When did the client start treatment for high blood pressure?

2. When did the client gain control of their blood pressure?

3. Please provide name, dosage and frequency of any blood pressure medications being taken?

If No:

1. When did the client stop treatment for high blood pressure?
- B. What is the client's Pulse Pressure?(ex. 65)
13. What is the client's SYSTOLIC blood pressure reading? (Number on top, example:135/75)
14. What is the client's DIASTOLIC blood pressure reading? (Number on bottom, Example:135/75)
15. Has the client EVER been convicted of a DWI, DUI, reckless driving, moving violation, license revocation or suspension?

If Yes: (Indicate all motor vehicle violations that apply)

- A. Moving Violations (If Yes)
 1. Going as far back as the client can, list the dates of as many moving violations starting with the earliest.
 2. Please provide any necessary details regarding the client's moving violation history.
- B. Reckless Driving (If Yes)
 1. List the dates of any reckless driving violations starting with the earliest.
 2. Please provide any necessary details regarding the client's reckless driving violations.
- C. DUI/DWI (If Yes)
 1. List the dates of any DUI/ DWI violations.
 2. Please provide any necessary details regarding the client's past DUI/DWI violations.
- D. License Suspension/Revocation (If Yes)
 1. List the dates of any license suspensions/revocations.
 2. Is the client's drivers license currently suspended/revoked?
 3. Please provide any necessary details regarding the client's past license suspension/revocation .
- E. Other (If Yes)
 1. Has the client been responsible for a motor vehicle accident?

2. Please provide any additional details regarding the client's driving record history.

16. Has the client EVER participated in any hazardous avocations? (Aviation, Climbing/Mountaineering, Gliding, Motor Sport, Parachuting, Scuba Diving, etc.)

If Yes: (Select all avocations that apply)

A. Aviation (If selected)

1. Does the client currently fly aircrafts?

a. If Yes: In which of the following capacities does the client fly?

1. Aerial Photography, Airline Crew, Commercial Pilot, Construction

Work, Crop Spraying, Private Pilot

a. How many total hours has the client flown in capacity?

b. How many hours will the client fly in the next 12 months in capacity?

c. Does the client fly outside the U.S.?

If Yes: Please list the countries the client flies to.
Please include the dates, duration and frequency of the flights.

2. Armed Services

a. What types of aircraft does the client fly?

b. What is the nature of the client's military flying?
(ex. attacker, Cargo, etc.)

c. Does the client have current orders for duty in combat or hazardous duty areas?

3. Flight Instruction, Helicopter Crew, Police Work

a. Please provide details regarding the client's history in this capacity. Include the types of aircrafts, number of hours, etc.

4. Survey Work

5. Test Pilot

6. Other

b. Select all aviation certificates the client holds.

1. None

2. Airline Transport

3. Commercial Pilot

4. Flight Instruction

5. Instrument Flight Rating (IFR)

6. Private Pilot

7. Student Pilot

8. Other

c. Please list the dates of any Aviation violations (at fault).

B. Climbing/Mountaineering (If selected)

1. Does the client currently participate or intend to participate in climbing/mountaineering?

If Yes:

a. What is the location and frequency of the client's climbing history?

b. What type of terrain does the client normally climb? (established trails, rock climbing, etc)

c. Does the client participate in any climbing outside the US? Please provide details.

d. Does the client participate in any ice or glacier climbing? Please provide details.

e. What average grade does the client climb? What is the maximum altitude?

f. What special equipment does the client use when climbing?

If No: When did the client last participate in Climbing/Mountaineering?

C. Gliding (Air Craft or Hang Gliding) (If selected)

1. Does the client currently participate in or intend to participate in Gliding (Air Craft, Hang Gliding)?

If Yes: Please provide the details of the clients gliding avocation. (include frequency, any certificates, type of gliding, etc.)

If No: When did the client last participate in gliding?

D. Motor Sport (If selected)

1. Does the client currently participate in or intend to participate in motor sports?

If Yes:

1. What is the client's auto racing experience?
2. What type of vehicle does the client race?
3. What type of race course does the client drive on?
4. What is the engine size and type of fuel?
5. What is the client's average and top speed when racing?
6. How often does the client race?
7. Name any organizations with which the client races.

If No: When did the client last participate in motor sports?

E. Parachuting (If selected)

If Yes: Please provide the details of the clients parachuting avocation. (include frequency, any certificates, type of parachuting, etc.)

If No: When did the client last participate in parachuting?

F. Scuba Diving (If selected)

If Yes:

1. What is the average depth of the client's dives? (feet)
2. What is the client's deepest dive? (feet)
3. What is the purpose of the client's dives? Select all that apply.

- a. Pleasure/Vacation
 - b. Wreck Diving
 - c. Treasure Trove Diving
 - d. Ice Diving
 - e. Depth Record Attempts
 - f. Other
4. How many scuba dives per year?
5. Select any scuba diving certifications the client holds:
- a. Basic certification
 - b. Open water certification
 - c. Advanced open water
 - d. Specialty courses (ice, cave, wreck, photography, night diving)
 - e. Dive Master
 - f. Assistant Instructor
 - g. Master Instructor
 - h. Master Scuba
 - i. Other
6. Is the client a member in any of the following diving associations?
- a. PADI-Professional Association of Diving Instructors
 - b. NAUI-National Association of Underwater Instructors
 - c. NASDS-National Association of Skin Diving Schools
 - d. YMCA-Young Men's Christian Association
 - e. Other
7. Please list any other scuba diving details:

If No:

1. When did the client last participate in scuba diving?
2. Please select the scuba diving capacities that the client used to participate in:
 - a. Pleasure/Vacation
 - b. Wreck Diving
 - c. Treasure Trove Diving
 - d. Ice Diving
 - e. Depth Record Attempts
 - f. Other

G. Other (If selected)

1. Does the client currently participate in or intend to participate in this hazardous activity?

If Yes:

- a. What activity does the client participate in?
- b. How often does the client participate in this activity?

(How many hours per week/month/year)

- c. Does the client have any specialized training or certifications?
- d. Please provide any additional information about the client's activity that would be helpful in reviewing their case.

If No: When did the client last participate in this hazardous activity?

17. Does the client plan on traveling outside of the US or Canada?
(Travel Warnings)

If Yes:

- A. Where will the client be traveling? (Country, City, etc.)
- B. How long will the client stay in each location to which they are traveling?
- C. What is the purpose of the client's travel? (i.e. Business, Vacation, etc.)

18. Has the client ever had or been treated for any other medical conditions? If yes, check all that apply:

- A. None
- B. Alcohol abuse
- C. Alzheimer's/dementia/cognitive impairment
- D. Anxiety
- E. Arthritis
 - 1. General
 - 2. Rheumatoid
- F. Asthma
- G. Atrial Fibrillation
- H. Cancer
 - 1. Breast
 - 2. Colon
 - 3. Leukemia
 - 4. Lung Cancer
 - 5. Lymphoma (Hodgkin's)
 - 6. Lymphoma (Non-Hodgkin's)
 - 7. Ovarian
 - 8. Prostate
 - 9. Skin
 - 10. Other
- I. COPD
- J. Coronary artery Disease
- K. Cerebrovascular Disease
- L. Crohn's Disease
- M. Depression

- N. Diabetes
 - 1. Type I (Insulin)
 - 2. Type II (Oral)
- O. Drug abuse
- P. Epilepsy
- Q. Heart murmur/valve disease
- R. Hepatitis
 - 1. Type A
 - 2. Type B
 - 3. Type C
- S. Irregular heartbeat/palpitations
- T. Kidney disease
- U. Lupus
- V. Cirrhosis
- W. Elevated Liver Functions (LFT)
- X. Multiple Sclerosis
- Y. Parkinson's Disease
- Z. Peripheral Vascular Disease
- AA. Sleep apnea
- BB. Stroke
- CC. Weight Reduction Surgery
- DD. Other

19. List all other details, considerations, APS summaries or quote related information not previously provided.