Health Questionnaire / I	nformal Applic	ation ———			
Agent Name:					
Client Name:				DOB:	
Male  Femal	e 🗌 He	ight: ft in	Weight:	Weight lost in pa	st year:
Intended face amount: \$		Term 🗌	UL 🗌	SUL 🗌	
Has the client ever used	nicotine? Yes	☐ No ☐ Produ	uct:	Frequency:	Last used:
	•	• •			
condition, list the relation	nship, and prov	ide age at diagnosis	and/or death.		please check the appropriate
Do you have diabetes?	Yes □ No	☐ Date	of diagnosis:		
Current A1C:	Type I 🗌	Type II □			
Current BP:	Total Choles	terol Level:	HD	L:	LDL:
Known medical conditio	ns with details (	e.g., cardiac issues, c	ancer, complicat	ions of diabetes)	

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Medication	Dosage		Reason for taking	
Are you providing medical r	ecords? Yes \( \square\) No \( \square\)			
Please list any doctors belov	v for which records have	no been provide	d.	
Name	Phone Number	Address	Last Seen	Type of physician
Name	Phone Number	Address	Last Seen	Type of physician
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For life applications with a f	ace amount of \$10,000,00	00 or more, we wi	ill assist you in seeking medi	cal record documentation from ers, you will be responsible for all
For life applications with a f physicians, hospitals, etc. Plexpenses incurred on behal	ace amount of \$10,000,00 ease note however, if the f of your client.	00 or more, we wi	Ill assist you in seeking medi formal with one of our carri	cal record documentation from

Signature

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Print Name



Date