

ALCOHOL USAGE

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. Does client presently consume alcoholic beverages? No Yes, If yes, please list

Beer: Quantity _____ oz. per day week month (select one)

Wine: Quantity _____ oz. per day week month (select one)

Liquor: Quantity _____ oz. per day week month (select one)

2. What was the date of initial treatment or diagnosis? _____ / _____ / _____

3. Were there any relapses from sobriety/abstinence? No Yes; please provide details and dates

4. Were there any legal problems (such as DUI) or other? No Yes; please provide details and dates

5. Have there been physical complications or additional psychiatric problems? No Yes; please provide details and dates, including use of other substances such as marijuana or cocaine

6. Does client currently participate in a group such as Alcoholics Anonymous? No Yes

7. Please list current medications (accurate name, dosage, and reason):

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
| | | |
| | | |

8. What is client's: Marital status: _____

Occupation: _____

Length of employment: _____

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

FAMILY HISTORY (ADDENDUM)

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

1. Has the proposed insured had relative(s) with any of the following:

Parent

Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)

Age of onset: _____ Date of death: _____

Brother

Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)

Age of onset: _____ Date of death: _____

Sister

Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)

Age of onset: _____ Date of death: _____

2. If yes to any of the above, please provide details/information
