Carriers/State:_____/_____ MP / FE

Clients Date of birth: ___/___/_____ Male/Female Height/weight: ____/_____

1) **Any form of tobacco/nicotine/ marijuana in last 12months:**	Yes/No
2) **Ever declined for life insurance:**	Yes/No
3) **Made a claim for or received any form of disability in last 5yrs**:	Yes/No
4) **Prescribed any meds for any reason in last 12months (even if not taking anymore):**	Yes/No
5) **Ever any Depression, Anxiety, Bipolar, PTSD, schizophrenia, Alzheimer's, dementia:**	Yes/No
6) **Ever Any heart conditions: (such as blood pressure, heart attack, angina, Congestive heart failure, heart surgery, chest pain, stents, heart value issues, pacemaker, A-Fib, anything?**	Yes/No
7) Ever Any Respiratory conditions: (such as, asthma, COPD, chronic bronchitis, every prescribed an inhaler, ever prescribed oxygen, shortness of breath)	Yes/No
8) Ever any conditions with : kidneys, liver, blood, auto-immune, stroke, Parkinson's, crohns, hepatitis, fibromyalgia, sleep apnea, seizures epilepsy?	Yes/No
9) **Ever any cancer, Diabetes, Stroke, Auto immune disease?**	Yes/No
10) any surgeries in last 10yrs? Prescribed any pain meds for any reason in last 10yrs?	Yes/No
11) been to the hospital for any reason in last 10yrs	Yes/No
12) Ever any Dui's or felonies or license suspension? Any tickets in the last 5yrs?	Yes/No

Explain any yes answer below (**WHEN DIAGNOSED, HOW BEING TREATED, EVER HOSPITALZED BECAUSE OF IT, EVER TAKEN TIME OFF OF WORK BECAUSE OF IT, IS IT NOW UNDER CONTROL, has treatment changed IN LAST 6MONTHS)**