

Broker Name: \_\_\_\_\_

Date: \_\_\_\_\_

Broker Telephone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Client Name: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Ft \_\_\_\_\_ In Weight: \_\_\_\_\_ Lbs

Height: \_\_\_\_\_ Ft \_\_\_\_\_ In Weight: \_\_\_\_\_ Lbs

Tobacco: Yes \_\_\_\_\_ No \_\_\_\_\_

Tobacco: Yes \_\_\_\_\_ No \_\_\_\_\_

All medications and Health Conditions:

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the applicant had a hospital stay in the past 5 years?

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Yes \_\_\_\_\_ No \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_

If "Yes", reason why, and date of last treatment:

If "Yes", reason why, and date of last treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Client*

*Spouse*

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Yes  No  Yes  No

Any pending surgeries? *If yes, describe:* \_\_\_\_\_

History of memory loss/dementia?

Any bone or joint problems (including osteoporosis)?

Use of a walker or wheelchair?

Arthritis? *If yes, type and current treatment:* \_\_\_\_\_

Back Issues? *If yes, describe:* \_\_\_\_\_

Any neurological conditions or mental disorders? \_\_\_\_\_

History of stroke or TIAs? *if yes, date of last episode:* \_\_\_\_\_

History of cancer? *If yes, type and date since last treatment:* \_\_\_\_\_

Diabetes? *If yes, type & A1C* \_\_\_\_\_