BASIC MEDICAL HISTORY SNAPSHOT OF PERSON REQUESTING COVERAGE

Person requesting coverage: Mr. / Mrs. / Ms. ______________________________

	Please Circle		If yes please write Doctor's name who last treated you.
Any heart, circulatory, blood pressure disorders?	YES	NO	
Any cancer history disorders? (Not limited to, but such as: tumors, cysts, melanoma, lymphoma, etc.)	YES	NO	
Any diabetes, thyroid, glandular disorders?	YES	NO	
Any cholesterol disorders?	YES	NO	
Any blood disorders?	YES	NO	
Any immune system disorders?	YES	NO	
Any respiratory disorder?	YES	NO	
Any eyes, ears, nose, throat disorders? (other than normal glasses, hearing aids, etc.)	YES	NO	
Any bones, muscle, back, skin, arthritis, joint disorders?	YES	NO	
Any sleep disorders?	YES	NO	
Any kidney, bladder, urinary disorders?	YES	NO	
Any digestive, intestines, stomach, liver, pancreas, or reproductive organ disorders?	YES	NO	
Any hospital visits, tests, or surgery that has been recommended, but not performed yet?	YES	NO	

LIFE INSURANCE RISK / HEALTH SNAPSHOT

Date: ____________________

Person requesting coverage: Mr. / Mrs. / Ms. ____________________

1. Please print and list any prescription medications you are taking or have taken in the last 30 days:

RX MEDICINE NAME	DOSAGE	FREQUENCY	REASON FOR RX	DOCTOR WHO PRESCRIBES

2. Your most current primary care physician:

   Full Name: ____________________

   Address: ____________________

   Suite Number: ____________________

   City: ____________ State: ____________ Zip: ____________

   Telephone: ____________________

   What specific ailments might your primary care physician treat other than regular annual physical, colds, etc? ____________________