



## Breast Cancer Questionnaire

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Client: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Product/Face Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\* TOBACCO/NICOTINE USE (*past or present*):  YES\*\*\*  NO

\*\*\*Please provide details as to any past or present use of tobacco or nicotine products:

\* Please provide the date of your initial breast cancer diagnosis and a brief summary regarding the clinical and diagnostic circumstances associated with the diagnosis:

\* Please note the specific *type* of breast cancer that was diagnosed:

\* Please note the “*Stage*” and “*Grade*” assigned to the tumor, along with any other details relative to the tumor pathology you were made aware of by your physician:

\* Do you know if estrogen & progesterone “receptors” were positive or negative? (*Please list as much information as you recall relative to receptor status, or other specialized testing, tumor markers, etc. at the time of initial excision and/or biopsy*)

\* What treatment modalities were utilized in the treatment of your breast cancer (local excision, radiation therapy, chemotherapy, etc.). Also please list the specific date all treatment concluded.

\* Subsequent to completion of treatment has there been any recurrence of breast cancer? If so, please provide details. (*dates, additional therapy/treatments, outcome, etc*)

\* **MEDICATIONS** - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

| MEDICATION | DOSE | MEDICATION | DOSE |
|------------|------|------------|------|
| 1.         |      | 5.         |      |
| 2.         |      | 6.         |      |
| 3.         |      | 7.         |      |
| 4.         |      | 8.         |      |

\* **FAMILY HISTORY:** (Family history may be a factor in determining rate class) Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:

**Cardiac Disease**             YES  NO            **Diabetes**             YES  NO  
**Stroke or TIA**                 YES  NO            **Cancer**                 YES  NO

Please provide details for any "YES" response below (attach additional sheet if necessary)

| FAMILIAL RELATIONSHIP | SPECIFIC CONDITION(S) | AGE WHEN DIAGNOSED | CURRENT AGE (if living) | DECEASED (list age @ time of death) |
|-----------------------|-----------------------|--------------------|-------------------------|-------------------------------------|
| FATHER                |                       |                    |                         |                                     |
| MOTHER                |                       |                    |                         |                                     |
| SIBLING 1             |                       |                    |                         |                                     |
| SIBLING 2             |                       |                    |                         |                                     |

\* Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date(s), insurance company name(s), reason provided for adverse action, and nature of prior submission (formal application vs. informal/trial submission), etc.

\* Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?