



Leukemia 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, including type of use, duration & frequency of use, date quit, etc.:

* **Specific type of leukemia diagnosed:**

Date of diagnosis:

Date of final treatment:

* **What was the specific stage of the leukemia?**

* **How was the leukemia treated?**

* **Has there been recurrence of the leukemia? If yes please provide details.** (*Dates, Additional Therapy/Treatments, Outcome*)

* **Was the proposed insured's spleen removed? If so, date of surgery.**

* **What are the current blood count readings? Current**

RBC (*red blood cell count*):
 WBC (*white blood cell count*):
 Platelet count:

* **How frequent does the proposed insured undergo follow-up?**

* **Is the proposed insured immune-compromised? (Unusually high frequency of colds, flus, or pneumonia) If yes, describe:**

* **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)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

* **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (Complete additional questionnaires, as indicated)

Condition(s) - List treatment and current status:

NONE - NO other medical conditions or health issues.

* **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/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?**