



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

* **Date of diagnosis:**

* **Date of final treatment:**

* **What was the specific type of the ovarian cancer:** (this information may be obtained from the physician that treated you and is essential for underwriting purposes)

* **What was the Stage/Grade of the cancer diagnosed?** (this information should be contained in the pathology report)

* **What was the “FIGO” score associated with your cancer?** (this information may be obtained from the physician that treated you and is essential for underwriting purposes)

* **Was there metastasis (spread) to other regions?**

* **How was the cancer treated?** (Please list ALL treatment provided)

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

*What are the most recent reading, and past levels of pre-treatment and follow-up “tumor markers”? (CA 125, CEA, etc. – please includes as many serial results as possible – both re and post-treatment - this information may be obtained from the physician that treated you and is essential for underwriting purposes)

⇒Tumor Marker (name and result): Date:
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(please attach an additional sheet if necessary to document as much data as possible)

* **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				

* 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?**