# POLYP, CYST, TUMOR, OR GROWTH

**CLIENT NAME:** _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

**Tobacco Use:** ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

**Type of Coverage:** ☐ Term ☐ UL ☐ Survivor **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

**Coverage Amount:** _____ **Anticipated Premium:** _____

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

***If yes, use separate sheet to provide this information, including age of onset and date of death***

| **PROPOSED INSURED'S EXISTING INSURANCE** | | | |
|---|---|---|---|
| Full Name of Company | Face Amount | Year Issued | Is Policy to be Replaced? |
| | | | |
| | | | |

1. What type of growth did client have? _____

2. When was it discovered? Date: _____

3. What is the specific location in or on the body where it is located?

_____

_____

4. How many were present or removed? _____

5. What type of treatment has client had? _____

_____

6. If removed surgically, what was the pathological diagnosis? ☐ Benign ☐ Malignant

If you have pathology report available, please provide it.

7. Is client taking any medication? (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

8. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

 