

# MENTAL DISORDERS

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

**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. Describe client's condition. Give the diagnosis.

\_\_\_\_\_

2. Date of first symptoms? \_\_\_\_\_

3. When did client last see doctor for this condition? \_\_\_\_\_

4. Has client been hospitalized  No  Yes; (list all)

Date: \_\_\_\_\_

Date: \_\_\_\_\_

5. Is client currently employed?  No  Yes

6. Has condition interfered with work?  No  Yes, If so, how long? \_\_\_\_\_

7. Is client disabled?  No  Yes; please give details

\_\_\_\_\_

8. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

\_\_\_\_\_

