

# 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

\_\_\_\_\_

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