FSA
Financial Security Associates

Risk Assessment- ALCOHOL

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	**Male** **Female**
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	**Term** **UL** **Whole Life** **2nd To Die**
Has Client EVER Used Tobacco? **YES** **NO**	**Date of Last Use:**
Specify All Types of Nicotine Used**:**	**Cigarettes** **Cigar** **Pipe** **Other:**
Has Client Been Treated for Alcohol Abuse? **YES** **NO**	**Date of Treatment:** **Name of Facility:**
Is Client Member of: **AA** **NA** **CA?**	**Date Joined:**
How often client attend?	
Has Client Ever Taken ANTABUSE? **YES** **NO**	**Date Last Used:**
Ever Convicted of Driving Offenses Related to Alcohol?	**Date & Details of Offense:**
Any Medical Problems Related to Alcohol? **YES** **NO**	**Details:** (such as liver disease or elevated enzymes)

Before Treatment, How Long Was Alcohol Used?	
What Was Frequency of Use?	
What Was Date of Last Alcohol Usage?	
Was There Also Drug Use?	**Yes** **No**
If Yes, What Type of Drugs?	
Before Treatment, How Long Were Drugs Used?	

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:_____

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