FSA
Financial Security Associates

Risk Assessment– Blood Pressure

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:**
When Was Client Diagnosed?	
What type of treatment or Lifestyle changes made?	
Is BP Currently Controlled? **YES** **NO**	**Last BP Reading:** **Date of Last Reading:**

Has Client Experienced Any complications from BP? **YES NO**	**Details:**
Has An Electrocaridagram Been Done? **YES NO**	**Date & Results:**
Does Client take any Medications for BP? **YES NO**	**List All RX:**
Family History of High Blood Pressure: (father, mother, siblings)	**Ages at Onset:** **Ages and Causes Death:**

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:_____

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