Risk Assessment– CANCER

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 Diagnosis?	**Date:**
Where was Cancer found?	
What Stage/Grade when Caner was found?	
Had Cancer Spread Beyond Original Site? **YES** **NO**	**Details:**
Were lymph nodes involved? **YES** **NO**	**Details:**

What Type of Treatment?	**Surgery:** **YES** **NO** **Chemotherapy?** **YES** **NO** **Radiation?** **YES** **NO**
When was date of last Treatment?	
When was last follow up with Physician?	
Is client currently on any Medications? **YES** **NO**	**List All RX:**
If Prostate Caner:	**PSA Before Treatment:** **PSA After Treatment:**
Family History of Cancer: (father, mother, siblings– which type, if any)	**Age at Onset:** **Age & Cause of Death:**

Additional Comments: (copy of pathology report will be needed)

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:___________________________

____