FSA
Financial Security Associates

Risk Assessment– CHOLESTEROL

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:**
Current cholesterol Level?	
Total HDL?	
How often is chol. checked?	
Is Client on Medication? **YES** **NO**	**Name of All RX:**

How Long Has Client been On Meds?	
Any changes in diet since diagnosis? **YES** **NO**	**Details:**
Does client exercise? **YES** **NO**	**Frequency & Duration:**
When was last Dr. visit?	**Date:**
Family History of Choles-terol: (father, mother, siblings)	**Age of Onset:** **Age & Cause of Death:**

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:_____

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