FSA
Financial Security Associates

# Risk Assessment– Hepatitis C

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|---|---|
| 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:** |
| What abnormality was first noted & when? | **(List symptoms & lab results)** |
| What was the diagnosis or cause for symptoms? | |

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|---|---|
| What type of evaluation was done & when? | |
| Is Client on any Medication? | **Name All RX:** |
| Is client treated for liver dis-order?<br>**YES NO** | **Date of Last Treatment:** |
| When did client last see Dr? | **Date & Details of Results:** |
| Does client use alcohol, wine, spirits or beer?<br>**YES NO** | **What type & How Frequently?** |
| If client does not use alcohol Now, have they in the past?<br>**YES NO** | **Date of Last Usage:**<br>**How Frequently When Used:**<br>**Why did patter of consumption change?** |

**Additional Comments:**

**This Questionnaire Must Accompany Your Formal Application.**

**FSA Preliminary Assessment:_____**

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