Risk Assessment– Melanoma

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 To-bacco? **YES** **NO**	**Date of Last Use:**
Specify All Types of Nicotine Used**:**	**Cigarettes** **Cigar** **Pipe** **Other:**
Date Diagnosed:	
Date when last saw Doctor:	
How often does client see Doctor:	
Clark Level (size/depth of The melanoma):	

What Type of Treatment?	**Surgery:**	**YES**	**NO**
	Chemotherapy?	**YES**	**NO**
	Radiation?	**YES**	**NO**
When was date of last Treatment?			
Family History of Cancer: (father, mother, siblings– which type, if any)	**Age at Onset:** **Age & Cause of Death:**		

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:_____

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