

Reliable Financial Group

A CPS Insurance Services, Inc. Affiliated Office

Companies, Products, and Services

www.relfingrp.com

9116 E Sprague B202, Spokane, WA 99206

Local (509) 926-2569 Fax (509) 921-1755 Toll Free (800) 364-3110

Breast Cancer

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. Your client may need to contact his/her physician to obtain needed information.

CLIENT: NAME _____	<input type="checkbox"/> M <input type="checkbox"/> F	DOB _____	AGE _____	HT _____	WT _____	STATE _____
AMT. REQUESTED \$ _____	MAX. ANNUAL PREMIUM \$ _____	/ TYPE OF INS. <input type="checkbox"/> UL <input type="checkbox"/> TERM YRS. LVL _____				
TOBACCO USE <input type="checkbox"/> NO <input type="checkbox"/> YES, TYPE _____	REPLACEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	CURRENT ANN. PREM. \$ _____				
LAST LIFE INSURANCE APP. YEAR _____	COMPANY _____	ACTION _____				
OCCUPATION _____	DOES CLIENT WORK FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF ANY DECEASED FAMILY, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____						
DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____						
DO YOU EXERCISE 3 OR MORE TIMES PER WEEK <input type="checkbox"/> NO <input type="checkbox"/> YES, DETAILS _____						
DATE OF LAST MEDICAL CHECKUP _____ DATE OF LAST EKG _____ AND RESULTS _____						
LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ IS CLIENT TREATED FOR BLOOD PRESSURE <input type="checkbox"/> NO <input type="checkbox"/> YES						
LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL <input type="checkbox"/> NO <input type="checkbox"/> YES						
AGENT: NAME _____	PHONE _____	E-MAIL _____				

(1) Date of diagnosis: _____ Date of last treatment: _____

(2) Exact name of the type of breast cancer that has been diagnosed: _____

(3) What was the Stage of the cancer?

- Stage 0 - Ductile carcinoma in-situ Stage 0 - Lobular carcinoma in-situ Stage 0 - Paget's disease of nipple
 Stage I Stage II Stage IIIA Stage IIIB Stage IV

(4) Was the cancer Graded? If so, what Grade was assigned?

- Grade I Grade II Grade III Grade IV

(5) How has the cancer been treated (please check all that apply)?

- Excisional biopsy (limited excision) Lumpectomy (wide excision)
 Partial Mastectomy Modified Radical Mastectomy Radical Mastectomy
 Radiation Therapy Chemotherapy Hormone Therapy Bone Marrow Transplant

(6) Does the proposed insured take any medications at this time? No Yes:

Name of Medication	Dates used	Quantity Taken	Frequency Taken

(7) Has there been any evidence of recurrence?

- No Yes Details: _____

(8) Has there ever been any kind of other cancer diagnosed for the proposed insured?

- No Yes Details: _____

(9) Does the proposed insured have any other medical conditions? If yes, please describe:

