



# Cancer (Generic) Questionnaire

Name

DOB

Gender

Desired face amount and type of coverage:	
Height and Weight:	
Date of or Age at Diagnosis:	
Type of Cancer:	
What was the stage of the cancer?	<input type="checkbox"/> Stage 0 (in-situ) <input type="checkbox"/> Stage III <input type="checkbox"/> Stage I <input type="checkbox"/> Stage IV <input type="checkbox"/> Stage II <input type="checkbox"/> Unknown
Were lymph nodes involved? If yes, how many?	
How was the cancer treated? (Check all that apply)	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Total excision <input type="checkbox"/> Hormonal therapy <input type="checkbox"/> Node dissection <input type="checkbox"/> Stem cell transplant <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Unknown or Other
List date treatment was completed:	
Any evidence of recurrence?	
Date/results of last follow-up imaging studies and/or lab testing:	
Medications currently being taken (provide dosage and frequency):	
Does the client currently smoke or ever smoked? If yes, provide date of last tobacco use:	
Has the client ever had any other major medical conditions? Provide diagnosis date, treatment, results,	

**Please return the completed form to you financial professional.**

All quotes are tentative, and are NOT BINDING, and SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process.