Underwriting Questionnaire Uterus/Cervical Cancer

HH Truist Life Insurance Services

Producer Name	Phone		Date	_
Client Name	Date of Birth			
☐ Male ☐ Female Face Amount	Face Amount Max Premium \$ _		\$ /yr.	
☐ Term ☐ Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No				
Frequency	Date of last use		Type	
Type of cancer ☐Endometrial ☐Adenocarcinoma ☐Leiomyosarcoma ☐Cervical	Date of diagnosis		_	
]1a	□2 □3 □2b	□4 □3 □4	
Treatment Total hysterectomy Cryosurgery/Laser Radiation Cone bio		otherapy	☐Hormonal therapy	
Date treatment completed Any evidence of recurrence _Yes _No				
Current frequency of checkups				
Date of most recent Pap smear Results?				
Name of Medication (prescription or other	erwise) Date	es Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:

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