

## CANCER—COLORECTAL CANCER QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$_____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: ____ft. ____in. Weight: ____lbs.		

(1) *Date of first diagnosis:* \_\_\_\_\_

(2) *Date of last treatment:* \_\_\_\_\_

(3) *Stage and grade of the cancer:*

- In situ                       Dukes' Stage B1                       Dukes' Stage C1                       Dukes' Stage D  
 Dukes' Stage A                       Dukes' Stage B2                       Dukes' Stage C2                       Other: \_\_\_\_\_

Other staging system used: \_\_\_\_\_ Stage of cancer: \_\_\_\_\_ Grade of cancer: \_\_\_\_\_

(4) *How was the cancer treated? Please check all that apply:*

- Surgery                       Radiation                       Chemotherapy  
 Other: \_\_\_\_\_

(5) *Is the proposed insured currently taking any medications? If yes:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(6) *How often does the proposed insured have a cancer screen to detect possible recurrence?*

- Every 3 months                       Every 6 months                       Yearly                       Every 2 Years                       Every 5 years

(7) *Has there been any evidence of recurrence? If yes, please provide details:* \_\_\_\_\_

\_\_\_\_\_

(8) *Does the proposed insured have any other medical conditions or are there other underwriting conditions?*

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