Life Risk Assessment Form

Agent Information

Email Completed Form to: **LIFE@asb.insure**

Agent Name: _____ *Agent Phone:* _____

Agent Email: _____

Client Name: _____ *Client Birth Date:* _____

Gender: ☐ *Male* ☐ *Female* *Height:* _____ *Weight:* _____ *State:* _____

Death Benefit Requesting: _____ ☐ *FE* ☐ *Term* ☐ *GUL* ☐ *IUL*

Present Nicotine Use:

☐ *None* ☐ *Cigarettes-Frequency of Use Per Day:* _____ ☐ *Cigars* ☐ *Pipe* ☐ *Dip* ☐ *Chew*
☐ *Nicotine Gum* ☐ *Marijuana* ☐ *Vape* ☐ *Other:* _____

Quantity Per Month: _____ *For Marijuana-What form is used?* _____ *How Often:* _____

Former Tobacco Use: List each type of tobacco, quantity and frequency used, and date of last use:

Medical/Personal History (Please click on condition name for required additional questionnaire)

Have you ever had, been told you had, or been treated for any of the conditions listed? *Check all that apply:

☐ Alcohol Usage ☐ Alzheimer's/Dementia/Cognitive Impairment ☐ Respiratory Disorders

☐ Arthritis ☐ Cancer-*Type and Stage*: _____ ☐ Coronary Artery Disease/Heart Attack

☐ Criminal Activity ☐ Crohn's ☐ Diabetes-*A1C*: _____ ☐ Drug Usage ☐ Epilepsy

☐ Heart Murmur/Valvular Disease ☐ Hepatitis ☐ Kidney Disease ☐ Liver Disease ☐ Lupus

☐ Marijuana ☐ Mental Health Disorders ☐ Multiple Sclerosis ☐ Sleep Apnea ☐ Stroke

☐ Auto-immune Disorders ☐ Aviation ☐ Avocations ☐ Foreign Nationals

☐ AFIB/Cardiomyopathy ☐ None ☐ Other, explain in box below

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Medications: (current and prescribed, even if not taking) ☐ **None**

Name of Medicine	Amount per Dosage	Taken # of times a day	Reason

Hospitalizations in the last 5 years: ☐ **None**

Contracted Companies? ☐ None