

Medical Conditions Guide

Name: _____

DOB: _____

Major Medical Impairments:

Major Non-Medical Impairments:

Policy Basics

Face Amount: _____

Plan Type: _____

Riders: _____

Personal Information

Gender: Male Female

Height (ft/in): _____

Weight (lbs): _____

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Active Prescriptions

Name: _____

Date: _____

Reason: _____

Dosage: _____

Frequency: _____

Name: _____

Date: _____

Reason: _____

Dosage: _____

Frequency: _____

Name: _____

Date: _____

Reason: _____

Dosage: _____

Frequency: _____

Health Metrics

Tobacco Use: Yes No

Blood Pressure (Systolic/Diastolic): _____

Cholesterol Profile:

➤ LDL (mg/dL): _____

➤ HDL (mg/dL): _____

➤ Total Cholesterol: _____

➤ Ratio: _____

Additional Information

Financial Information

Partner Agency Comments

Case Synopsis