



Risk Assessment– Anxiety & Depression

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	Male Female
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	Term UL Whole Life 2nd To Die
Has Client EVER Used To- bacco? YES NO	Date of Last Use:
Specify All Types of Nicotine Used:	Cigarettes Cigar Pipe Other:
Describe Client's Condition & Diagnosis If Known:	
Date of First Symptoms:	
When Was A Doctor Last Seen?	
Has Client Ever Been Hospi- talized? YES NO	List All Stays:

Is Client Currently Employed?	Yes	No
Has Condition Ever Interfered With Work? YES NO	Details:	
Is Client Disabled? YES NO	Date When Declared Disabled:	
Is Client Taking Medications? YES NO	List All RX:	
Has Client Ever Attempted Suicide or had suicidal thoughts? YES NO	Date & Details:	

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment: _____
