MVP FINANCIAL SERVICES

Preliminary Medical History Form

Not an Application for Insurance

Producing Agent Name: _____

Agent Phone / Email: _____/_____

Personal Information

1. Proposed Insured Information

Name: _____Date of Birth:_____/_____/_____ U.S. Citizen? ☐Y ☐N

2. Other Proposed Insured

Name: _____ Date of Birth:_____/_____/_____ U.S. Citizen? ☐Y ☐N

Does either insured use tobacco or nicotine products? ☐Y ☐N List person, type, frequency: _____

_____

If quit, list dates of use: _____/_____/_____to _____/_____/_____

Product Information

Product Type/Duration: _____ Face Amount Desired: _____

Reason for Insurance: _____ Writing State:_____ Replacement: ☐Y ☐N

Medical History

Physician Information:
(Name and address of proposed insured's physicians. If none, write "None.")

Primary Proposed Insured_____

_____

Other Proposed Insured_____

_____

Name of insured, Physician name, date, reason, findings and treatment at last visit:

_____

_____

_____

_____

3. Height and Weight

Primary Proposed Insured _____ft._____ in._____ lbs. **Other Proposed Insured** _____ft. _____in._____ lbs.

Has any proposed insured had any weight change in excess of 10 lbs. in the past year? ☐ Yes ☐ No

If yes, please complete: Name _____ Loss_____ lbs. Gain _____lbs.

Reason _____

4. Family History

	Age if Living	Age at Death	Heart Disease?	Cancer History?
Primary Proposed Insured				
Father	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Mother	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Brother(s)	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Sister (s)	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Other Proposed Insured				
Father	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Mother	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Brother(s)	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____
Sister (s)	_____	_____	☐No ☐Yes, *age of onset*_____	☐No ☐Yes, *age of onset*_____ *Cancer Type:*_____

5. Personal Health History

*Complete questions A through G for all proposed insureds who are applying. If yes answer applies to any proposed insured, provide details, such as**: proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)** or **recommended treatment** in the area provided.*

A. Has any proposed insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

1	heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart?	☐No ☐Yes
2	a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins?	☐No ☐Yes
3	cancer, tumor, masses, cysts, or other such abnormalities?	☐No ☐Yes
4	diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system?	☐No ☐Yes
5	colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine?	☐No ☐Yes
6	a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine?	☐No ☐Yes

7 asthma, bronchitis, emphysema, sleep apnea or other breathing/lung disorder? ☐No ☐Yes

8 seizures, a disorder or the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder? ☐No ☐Yes

9 arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐No ☐Yes

(If any question above is answered yes, explain on next page.)

Name of Proposed Insured **Details:**

B. Is any proposed insured currently taking any medication, treatment or therapy or under medical observation? ☐No ☐Yes

(If yes, explain.)

Name of Proposed Insured **Details:**

C. Has any proposed insured in the past three years had but not sought treatment for:

1 fainting spells, nervous disorder, headaches, convulsions or paralysis? ☐No ☐Yes

2 any pain or discomfort in the chest or shortness of breath? ☐No ☐Yes

3 disorders of the stomach, intestines or rectum, or blood in the urine? ☐No ☐Yes

(If any question above are answered yes, explain below.)

Name of Proposed Insured **Details:**

If yes answer applies to any proposed insured, provide details, such as: ***proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)*** *or* ***recommended treatment*** *in the area provided.*

D. Has any proposed insured ever:

1 sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? ☐No ☐Yes

2 used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? ☐No ☐Yes

(*If yes answered to D1 or D2, explain below.)*

Name of Proposed Insured **Details:**

E. Has any proposed insured ever been diagnosed or treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ☐No ☐Yes

(If yes, explain on next page.)

Name of Proposed Insured **Details:**

F. In the past 10 years, has any proposed insured:

1 been hospitalized, consulted a health care provider or had any illness, injury or surgery? ☐No ☐Yes

2 had any laboratory tests, treatments/diagnostic procedures, including x-rays, scans or EKGs? ☐No ☐Yes

3 been advised to have any diagnostic test, hospitalization or treatment that was not completed? ☐No ☐Yes

4 received or claimed disability or hospital indemnity benefits or a pension for injury, sickness, disability or impaired condition? ☐No ☐Yes

(If any question above are answered yes, explain.)

Name of Proposed Insured **Details:**

G. Does any proposed insured have any symptoms or knowledge of any condition that is not disclosed above? ☐No ☐Yes
(If yes, explain.)

Name of Proposed Insured **Details:**

Does either proposed insured have plans of any foreign travel, or participate in any hazardous sports, or hobbies such as scuba, racing, flying, hang gliding, rock climbing etc? If yes, provide details below.

Other comments or notes of interest: (Competition details, other applications pending, etc.)