

LEUKEMIA QUESTIONNAIRE

Insured's Name: _____ DOB: _____ State: _____ Sex: M / F
Height: Ft. In. Weight: _____ Face Amount: _____
Tobacco use in the past 5 years: No Yes Details: _____
Producer: _____ State: _____ Phone: _____ E-mail: _____

Proposed Insured please answer the following:

1. Type of Leukemia (i.e. Chronic Lymphocytic (CLL), Acute Lymphoblastic (ALL), Chronic Myelogenous Leukemia (CML), Acute Non-Lymphoblastic (ANLL), Promyelocytic (PL)):

2. Date of Diagnosis:

3. How was / is your Leukemia being treated (i.e. chemotherapy, bone marrow transplant, etc.)?

4. Duration of treatment:
 Date of last treatment:

5. Are you currently in remission? Yes No
 If yes, how long have you been in remission?

6. Current platelet count:

7. Are you on any medications? Yes No
 Names and Dosages:

8. Is there a family history of cancer? Yes No

9. Date you last consulted your physician(s):

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____