

Cenco Insurance Marketing Corporation  
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## Questionnaire For: Cancer

Information gathered will be used in the evaluation of the insurability of the applicant. Offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

Agent's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Male ( ) Female ( ) Height \_\_\_\_\_ Weight \_\_\_\_\_ Smoker ( ) Non Smoker ( )  
Amount of Coverage \$ \_\_\_\_\_ Product Type \_\_\_\_\_

1. Type of malignancy or cancer?  
 Bladder  Breast  Cervical  Color or Rectal (also complete question #7)  
 Hodgkin's Disease  Melanoma\* (also complete question #8)  
 Prostate (also complete question #9)  Skin  Other \_\_\_\_\_

\*If melanoma or skin cancer, please detail:

Type \_\_\_\_\_ Location on body \_\_\_\_\_

2. Has tumor or malignancy metastasized?  Yes  No, please detail:  
Date diagnosed: Month \_\_\_\_\_ Year \_\_\_\_\_

3. Stage of tumor or malignancy:  
T \_\_\_ N \_\_\_ M \_\_\_ Or  
 1  2  2A  2B  3  3A  3B  4  5  
 Other \_\_\_\_\_

4. Types of treatment used (check all applicable):  
 Surgical removal of malignancy  
 Chemotherapy  
 Radiation therapy  
 Hormonal (orchidectomy – des. Lupron)  
 Other \_\_\_\_\_

5. Date of last treatment received:  
Month \_\_\_\_\_ Year \_\_\_\_\_

6. Has there been any medical evidence of recurrent cancer?  
 Yes  No If yes, please detail: Month \_\_\_\_\_ Year \_\_\_\_\_

7. Duke's Scale (for colon and rectal cancer only):  
 A1  B1  B2  C1  C2  D

8. Clark's Level (for Melanoma only):  
 I  II  III  IV  V      Depth of Melanoma \_\_\_\_\_

9. (For prostate cancer only):  
Stage: \_\_\_\_\_  
T \_\_\_ N \_\_\_ M \_\_\_  
Or  A1  A2  B1  B2  C1  C2  D  
Gleason's Grade:  2 or 3  4 or 5  6 or more  
Results of most recent PSA test \_\_\_\_\_

10. Has a parent, brother or sister died prior to age 65, other than by accident?  Yes  No  
If yes, please detail \_\_\_\_\_  
\_\_\_\_\_

11. Does the client exercise three or more times per week?  Yes  No  
If yes, please detail \_\_\_\_\_

12. Client's occupation \_\_\_\_\_

13. Please list any other illnesses or impairments; along with any and all medications currently being taken, include the dosage and frequency of each:  
\_\_\_\_\_  
\_\_\_\_\_