

# Thyroid Cancer Questionnaire

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male /  Female  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ State: \_\_\_\_\_ Smoker:  Y /  N Face Amount: \_\_\_\_\_  
Type of Insurance:  Universal Life  Whole Life  Survivorship  Term (# of years \_\_\_\_\_)

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1. When was the proposed insured first diagnosed with thyroid cancer? \_\_\_\_\_

2. What type of thyroid cancer was diagnosed?

- Papillary thyroid cancer
- Follicular thyroid cancer
- Medullary thyroid cancer (  Sporadic  Isolated familial medullary)
- Anaplastic carcinoma
- Thyroid lymphoma

3. Did the cancer spread to lymph nodes or other organs?  Yes  No

If yes, provide details and location(s): \_\_\_\_\_  
\_\_\_\_\_

4. What treatments did the proposed insured receive?

- |  |                             |
|--|-----------------------------|
| <input type="checkbox"/> Surgery                 | Date and details: _____     |
| <input type="checkbox"/> Radioactive Iodine      | Date and details: _____     |
| <input type="checkbox"/> THS Suppression Therapy | Date and details: _____     |
| <input type="checkbox"/> Chemotherapy            | How long did it last: _____ |
| <input type="checkbox"/> Other: _____            | _____                       |

5. Is the proposed insured current taking any medication(s)?  Yes  No

If yes, provide name, dosage and frequency of medication(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX TO 603-778-7918 or E-MAIL TO [sdonovan@uuinc.com](mailto:sdonovan@uuinc.com).