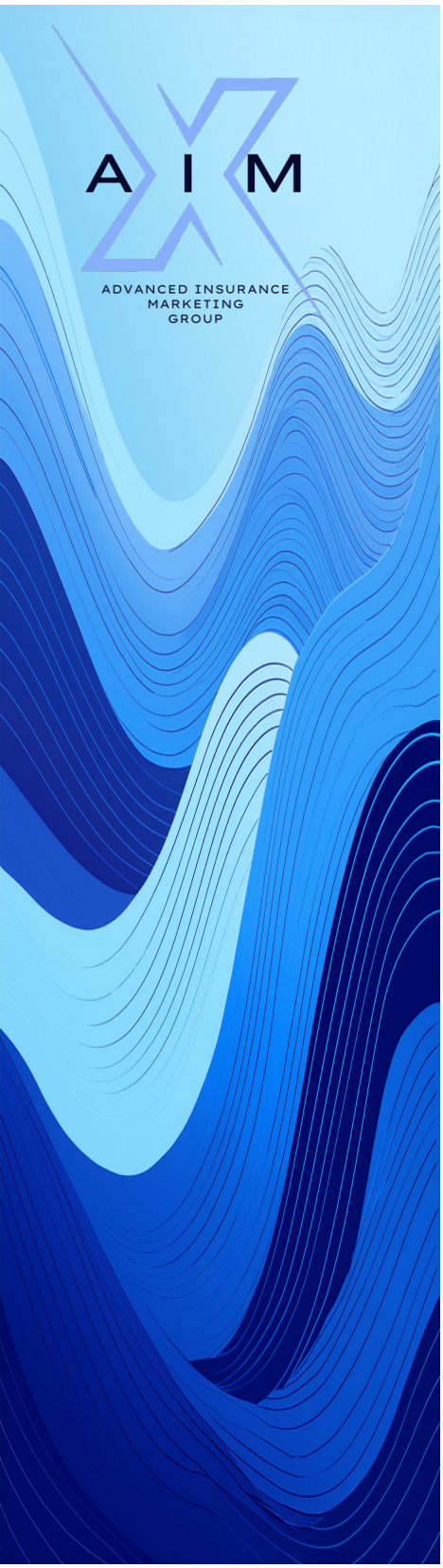


Client Name:_____ DOB:_____

Height:_____ Weight:_____ Weight Loss in Past Year (lbs)_____

Have you used any tobacco in any form within the past 10years? ☐ YES ☐ NO

If yes, then indicate type used and date last used:_____

Have you used cannabis in any form within the past 12 months? ☐ YES ☐ NO

If yes, then indicate type used and how often:_____

Are you currently taking any drugs (Prescription and Over the Counter (OTC)):

☐ YES ☐ NO

If yes, please indicate medication name, reason and year prescribed:

Medication Name	Reason Taken	Year prescribed

Are you a US Citizen ? ☐ YES ☐ NO

If no, are you a permanent resident in the US ? ☐ YES ☐ NO

Do you have an iTIN number ? ☐ YES ☐ NO

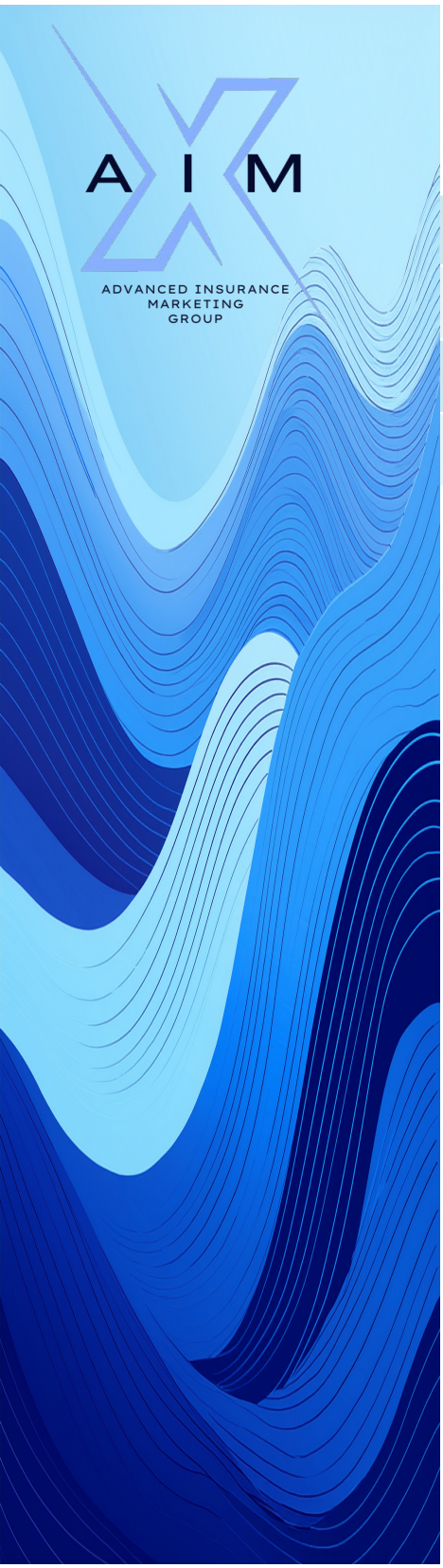
Any DUI, DWI or reckless driving convictions ? ☐ YES ☐ NO

If yes, then indicate and provide dates:_____

Any intended travel outside of the US ? ☐ YES ☐ NO

If yes, then indicate location and duration:_____

This information will be used for preliminary non-binding assessment only. It does not represent a contract or committal to a mortality risk associated with Legacy Full Circle or any life insurance carrier.



FAMILY HISTORY:

Any family history of cancer or cardiovascular disease prior to age 60 of parents or siblings:

Family Member	Gender	Alive/ Deceased	Cause of Death	Age at Death

In the past 25 years have you had, been told you have, and/or been treated for:

Dizziness, headaches, seizures, convulsions, stroke, memory loss or any disease of the brain or nervous system? ☐ YES ☐ NO

Depression, anxiety or any psychological or emotional condition or disorder? ☐ YES ☐ NO

Shortness of breath, asthma, emphysema, chronic obstructive pulmonary disease (COPD) or any lung or respiratory disorder? ☐ YES ☐ NO

Hepatitis, chest pain, irregular heartbeat, murmur, heart attack or any disorder of the heart or blood vessels? ☐ YES ☐ NO

Diabetes (sugar), albumin, sexual transmitted disease (STD), or any disorder of the kidney, bladder, prostate or reproductive organs, thyroid, or endocrine disorder? ☐ YES ☐ NO

Cancer, tumor, polyp, or disorder of the lymph glands or breasts? ☐ YES ☐ NO

Anemia or any disorder of the blood ? ☐ YES ☐ NO

Rheumatoid arthritis or any disorder of the muscles, bones, joints or spine ? ☐ YES ☐ NO

Persistent or unexplained fatigue, fever or illness ? ☐ YES ☐ NO

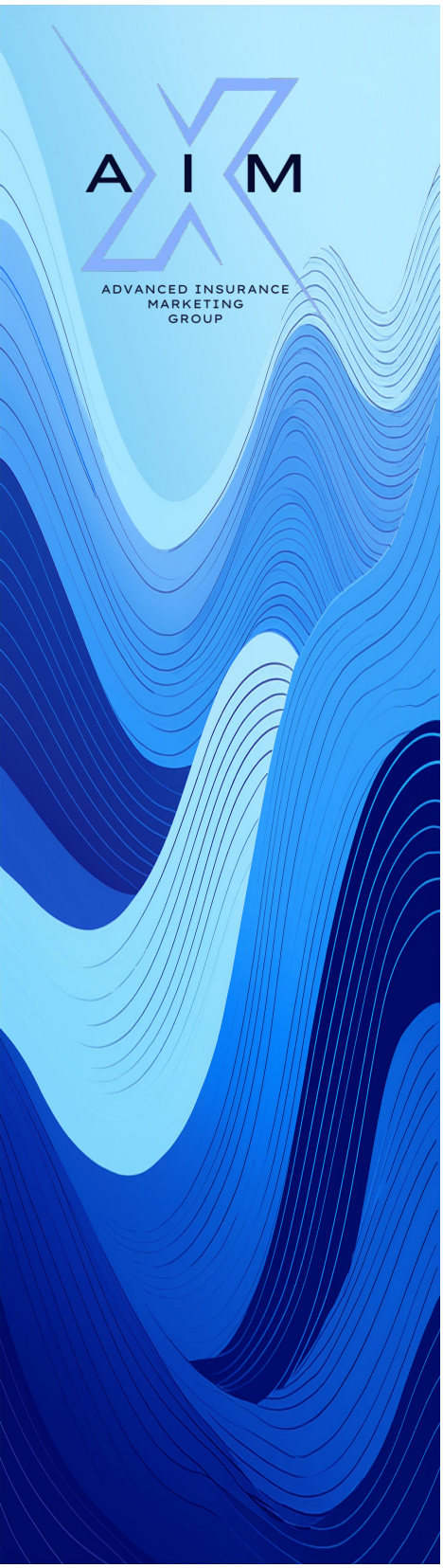
Sought, received, and/or been recommended treatment for use of alcohol or drugs (marijuana, cocaine, heroin, amphetamine, hallucinogens, tranquilizers, sedatives, narcotics, or legally prescribed drugs)? ☐ YES ☐ NO

In the past 10 yrs. have you ever used any of the above drugs? ☐ YES ☐ NO

Has a member of the medical profession ever diagnosed you as having or treated you for Acquired Immune Deficiency Syndrome (AIDS)? ☐ YES ☐ NO

Have you ever been declined, postponed or rated on ANY prior insurance consideration submissions ? ☐ YES ☐ NO

This information will be used for preliminary non-binding assessment only. It does not represent a contract or committal to a mortality risk associated with Legacy Full Circle or any life insurance carrier.



PLEASE PROVIDE EXPLANATIONS, DATES DIAGNOSED and TREATMENT COMPLETION DATES TO ALL YES ANSWERS:
(PROVIDE AS MUCH DETAIL AS POSSIBLE FOR A MORE ACCURATE PRE_ASSESSMENT)

This information will be used for preliminary non-binding assessment only. It does not represent a contract or committal to a mortality risk associated with Legacy Full Circle or any life insurance carrier.