



Trinity Life Insurance Company

ADMINISTRATIVE OFFICE: PO BOX 5205 • FRANKFORT, KY 40602-5205

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FAMILY HISTORY QUESTIONNAIRE

To be used when family history is a rate class qualifier.

Applicant Name: _____ Date of Birth: _____

Family Record: Check condition(s) and relationship of any blood relative who has or had any the conditions listed below.
Use comment line for any "yes" answers.

F = Father, M = Mother, B = Brother, S = Sister

	F	M	B	S	Comments:
Alcoholism	___	___	___	___	_____
Anemia	___	___	___	___	_____
Asthma	___	___	___	___	_____
Bleeding Tendency	___	___	___	___	_____
Cancer	___	___	___	___	_____
Heart Disease	___	___	___	___	_____
Diabetes	___	___	___	___	_____
Emphysema	___	___	___	___	_____
Epilepsy	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
Kidney Disease	___	___	___	___	_____
Leukemia	___	___	___	___	_____
Liver Disease	___	___	___	___	_____
Mental Illness	___	___	___	___	_____
Multiple Sclerosis	___	___	___	___	_____
Nervous Breakdown	___	___	___	___	_____
Overweight	___	___	___	___	_____
Sickle Cell Anemia	___	___	___	___	_____
Stroke	___	___	___	___	_____
Suicidal Tendencies	___	___	___	___	_____

	Living		Deceased	
	Age	Health	Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

To the best of my knowledge I attest that the information stated on this form is true and accurate.

Signature of Applicant: _____

Date: _____

Witness: _____

Date: _____