



**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

### FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

**If yes, use separate sheet to provide this information, including age of onset and date of death**

### PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of first diagnosis: \_\_\_\_\_

2. Is the atrial fibrillation/flutter:  Chronic (permanent)  Proxysmal (intermittent)

3. Are there any symptoms with the irregular heart beat?

Black-out  Dizziness (light-headedness)/faint feeling

Palpitations  Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:

ECG \_\_\_\_\_

Stress test \_\_\_\_\_

Echocardiogram \_\_\_\_\_

Holter monitor \_\_\_\_\_

5. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:

Coronary heart disease  Alcohol

Thyroid disease  Cardiomyopathy

Mitral valve disease  Unknown

Other, give details \_\_\_\_\_

7. Are there any other health issues? (additional questionnaires may be required)  No  Yes; please give details

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