

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. List date(s) of diagnosis and type of coronary artery disease: _____

2. Does client's family have any history of heart disease? No Yes; list family member(s) and details

3. Has client had any of the following?:

Heart attack Date: _____ / _____ / _____ Heart failure Date: _____ / _____ / _____

Coronary angioplasty (PTCA) Date: _____ / _____ / _____ Valve surgery Date: _____ / _____ / _____

4. Number of vessels by-passed? _____

5. How badly were the vessels occluded (percentage)? _____

6. Has a follow-up stress (exercise) ECG been completed since procedure?

No Yes, Normal Date: _____ / _____ / _____ Yes, Abnormal Date: _____ / _____ / _____

7. Has client had any chest discomfort since the procedure? No Yes; please provide details

8. Has client had any of the following?:

Abnormal lipid levels Irregular heart beats Elevated homocysteine Overweight Elevated cholesterol

High blood pressure Diabetes Peripheral vascular disease Cerebrovascular or carotid disease

9. Is client on any medications now? (accurate name, dosage, and reason)

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
| | | |
| | | |
| | | |

10. Does client have any other health issues? (additional questionnaires may be required) No Yes; please give details