

HEART DISEASE—GENERAL CONCEPTS

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ft. _____in. Weight: _____lbs.		

(1) Date(s) or frequency of episode(s) of symptoms relating to Coronary Heart Disease:

- (a) Angina pectoris: _____
- (b) Coronary thrombosis/occlusion: _____
- (c) Coronary insufficiency: _____
- (d) Myocardial infraction (heart attack): _____

(2) Provide dates if any of the following tests or revascularization procedures have been done?

- Resting EKG: _____ Stress EKG: _____
- Thallium Stress EKG: _____ Echocardiogram: _____
- Coronary Catheterization: _____ Coronary Angioplasty: _____
- Percutaneous transluminal angioplasty (PTCA): _____ Directional Coronary Atherectomy: _____
- Rotational Atherectomy: _____ Coronary Artery Stents: _____
- Laser treatment: _____ Perfusion Balloon Catheter: _____
- Bypass Surgery: _____ Number of vessels involved: _____
- Other: _____

(3) Please check if the proposed insured as been diagnosed with the following conditions:

- Elevated Cholesterol - most recent known level: _____ High blood pressure - most recent reading: _____
- Diabetes - age of onset: _____ Recent A1C test result: _____ (please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
- Other: _____

(4) Does the proposed insured take any current medications, including preventative aspirin? No Yes Details:

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(5) Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?

- No Yes Details: _____

(6) Does the proposed insured engage in any regular exercise or sporting activity?

- No Yes Details: _____

(7) Are there any other conditions that may impact life underwriting? If yes, please describe: _____
