

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 Disability **Coverage Amount:** _____
Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____
Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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 the date(s) of the angioplasty (PTCA): _____
 2. How many vessels required the procedure? _____
 3. Why was an angioplasty done? (give specific details)

4. Does client's family have any history of heart disease? No Yes
 5. Has client had either of the following? Heart attack _____ (date), Bypass surgery _____ (date)

6. Has a follow-up stress (exercise) ECG been completed since procedure?
 Yes, normal _____ (date) Yes, abnormal _____ (date) No
 7. Has client had any chest discomfort since the procedure? No Yes; please give details

8. Has client had any of the following?
 abnormal lipid levels diabetes overweight elevated homocysteine high blood pressure peripheral vascular disease
 irregular heart beats cerebrovascular carotid disease

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

(Accurate) Name of Medication	Dosage	Reason

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

