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?

Generic Cardiac Questionnaire

SECTION I: AGENT INFORMATION

Full Name of Agent	
Address Line 1	
Address Line 2	
City, State, Zip	
E-Mail	
Business Phone	
Cell Phone	
Home Number	
Fax Number	

SECTION II: CLIENT BACKGROUND INFORMATION

Full Name	
Sex	◇ Male ◇ Female
Date of Birth	
Height	
Weight (if weight changed in the last 12 months, please indicate)	
Type of Product	◇ Term Life ◇ Universal Life ◇ Whole Life ◇ Second to Die ◇ Variable Life
Coverage Amount	
Desired Premium Range	
Occupation (If not currently employed, explain i.e. Retired, Disabled, Social Security Disability, Workmans Comp)	
Ever used nicotine	◇ Yes ◇ No
Still using nicotine	◇ Yes ◇ No ◇ Not Applicable
Date Stopped	
List types of nicotine used	

SECTION III: CLIENT MEDICAL INFORMATION

Most significant medical problem	
Date condition first diagnosed	
Is client currently seeing a doctor for the above condition	◇ Yes ◇ No
Date of last visit	
Most recent BP reading	
List all medications, including dosage and frequency, that the client is currently taking:	
List any immediate relatives (parents or siblings) who have died of heart disease, cancer, or diabetic complications prior to the age of 60:	
Describe any other impairment, medical or otherwise, which may affect the underwriting process:	
Prior company action (Name of company, rating, premium)	
Types and dates of surgery or hospital treatment?	

SECTION IV: GENERAL HEART CONDITION QUESTIONS

Has the client ever experienced syncope (fainting), palpitations, or dizziness? If so, provide details:

Describe any restrictions placed on the clients activities:

What was the date and type (treadmill, nuclear treadmill, chemically induced, etc) of the clients last stress test?

What were the results of that test?

Does the client carry a pill (nitroglycerin) or does client ever wear a patch for chest pain?

◇ Yes

◇ No

Does the client suffer from Angina (chest pain)? If so, please provide official diagnosis:

Does the client carry nitroglycerine pills? If so, when was the last time they used them?