CONGESTIVE HEART FAILURE

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. Date of first diagnosis: _____

2. What is the cause of the CHF? _____

3. Has the client had surgical heart repair?

☐ No ☐ Yes; type: _____ Date: _____ / _____ / _____

4. Does client have a history of any of the following? (provide details)

☐ Hypertension _____

☐ Coronary artery disease _____

☐ Chronic obstructive pulmonary disease _____

☐ Pacemaker _____

5. Has an angiogram, echocardiogram, stress test, or heart scan been done?

☐ No ☐ Yes; please give details and provide a copy if available _____

_____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

