

**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. What type of murmur does client have?

- Aortic stenosis       Aortic regurgitation       Aortic insufficiency  
 Mitral stenosis       Mitral regurgitation       Mitral insufficiency  
 Pulmonic stenosis       Flow murmur       Innocent murmur

2. When was the heart murmur first discovered? \_\_\_\_\_

3. Does client have a history of rheumatic fever?  No  Yes

4. When was the client last seen by a physician for the heart murmur? \_\_\_\_\_

5. When was the last echocardiogram done? \_\_\_\_\_ What were the results? \_\_\_\_\_

6. Was a cardiac catheterization ever done  No  Yes; please give date \_\_\_\_\_

7. Does client have any symptoms or any limitation of activities?  No  Yes; please give details

8. Has client had any heart surgery or has surgery been discussed?  No  Yes; please give details

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

(Accurate) Name of Medication	Dosage	Reason

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