STENT

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. When and where was the stent put in? _____

2. What type of stent was put in? _____

3. Why was the stent put in? _____

_____

4. How many vessels were involved?_____

5. Has the applicant had an imaged stress test done? ☐ No ☐ Yes; if yes, when and what were the results?

_____

_____

6. What type of follow-up testing has been done and what were the results? _____

_____

7. Was there a heart attack prior to the stent being put in? ☐ No ☐ Yes;

8. Is there family history of heart disease? ☐ No ☐ Yes; please give details

_____

_____

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

