

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 first diagnosed: _____ Most recent episode occurred: _____

2. Is the irregular heartbeat due to (check all that apply):

- Premature supraventricular atrial beats (PACs)
- Premature ventricular beats (PVCs)
- Multifocal
- Bigeminy or trigeminy
- Ventricular tachycardia

3. Are there any symptoms with the irregular heartbeat?

- Black-out Dizziness (lightheadedness)/faint feeling Palpitations Chest discomfort

4. Have any of the following tests been done? (If so, please give date and results)

- ECG Date: _____
- Stress test Date: _____
- Echocardiogram Date: _____
- Holter monitor Date: _____

5. The cause of the irregular heart beat is due to: Heart disease Alcohol Thyroid disease Unknown or other _____

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

(Accurate) Name of Medication	Dosage	Reason

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

