

**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. List date(s) of diagnosis and type of coronary artery disease: \_\_\_\_\_

2. Does client's family have any history of heart disease?  No  Yes; list family member(s) and details

3. Has client had any of the following?:

Heart attack Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Heart failure Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Coronary angioplasty (PTCA) Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Valve surgery Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Which coronary artery vessels were bypassed (or provide number if unknown)? \_\_\_\_\_

5. Were arteries or veins used as grafts for the bypass? \_\_\_\_\_

6. How badly were the vessels occluded (percentage)? \_\_\_\_\_

7. Has a follow-up stress (exercise) ECG been completed since procedure?

No  Yes, Normal Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Yes, Abnormal Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

8. Has client had any chest discomfort since the procedure?  No  Yes; please provide details

9. Has client had any of the following?:

Abnormal lipid levels  Irregular heart beats  Elevated homocysteine  Overweight  Elevated cholesterol

High blood pressure  Diabetes  Peripheral vascular disease  Cerebrovascular or carotid disease

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

| (Accurate) Name of Medication | Dosage | Reason |
|-------------------------------|--------|--------|
|                               |        |        |
|                               |        |        |
|                               |        |        |

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