

**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 was the cause of heart failure (i.e., what is the specific diagnosis)? \_\_\_\_\_

2. When was the diagnosis made? \_\_\_\_\_

3. Has client had surgical heart repair?  No  Yes; please give details

4. Does client have a history of any of the following (please provide details or complete the questionnaire for the condition):

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 specifically including the ejection fraction (EF).

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