

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. How long has this abnormality been present? _____

2. Please check the type(s) of valve disorder present:

Mitral stenosis Mitral regurgitation Mitral valve prolapse

3. Have any of the following occurred?

Chest pain No Yes

Trouble breathing No Yes

Heart failure No Yes

Palpitations No Yes

Atrial fibrillation/flutter No Yes

3b. Has client received any treatment for this condition? Dates and details: _____

3c. Severity of condition: ___ Mild ___ Moderate ___ Moderate to Severe ___ Severe

4. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease, etc.)? No Yes; please give details

5. Have additional studies been completed? (check all that apply)

Echocardiogram Date: _____ Results: _____

Cardiac catheterization Date: _____ Results: _____

None

6. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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