

## HEART DISEASE—GENERAL CONCEPTS

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

**(1) Date(s) or frequency of episode(s) of symptoms relating to Coronary Heart Disease:**

- (a) Angina pectoris: \_\_\_\_\_
- (b) Coronary thrombosis/occlusion: \_\_\_\_\_
- (c) Coronary insufficiency: \_\_\_\_\_
- (d) Myocardial infraction (heart attack): \_\_\_\_\_

**(2) Provide dates if any of the following tests or revascularization procedures have been done?**

- Resting EKG: \_\_\_\_\_  Stress EKG: \_\_\_\_\_
- Thallium Stress EKG: \_\_\_\_\_  Echocardiogram: \_\_\_\_\_
- Coronary Catheterization: \_\_\_\_\_  Coronary Angioplasty: \_\_\_\_\_
- Percutaneous transluminal angioplasty (PTCA): \_\_\_\_\_  Directional Coronary Atherectomy: \_\_\_\_\_
- Rotational Atherectomy: \_\_\_\_\_  Coronary Artery Stents: \_\_\_\_\_
- Laser treatment: \_\_\_\_\_  Perfusion Balloon Catheter: \_\_\_\_\_
- Bypass Surgery: \_\_\_\_\_ Number of vessels involved: \_\_\_\_\_
- Other: \_\_\_\_\_

**(3) Please check if the proposed insured as been diagnosed with the following conditions:**

- Elevated Cholesterol - most recent known level: \_\_\_\_\_  High blood pressure - most recent reading: \_\_\_\_\_
- Diabetes - age of onset: \_\_\_\_\_ Recent A1C test result: \_\_\_\_\_ (please ask us for our Diabetes Questionnaire)
- Family history of heart disease. If yes, who and at what age(s) diagnosed: \_\_\_\_\_
- Other: \_\_\_\_\_

**(4) Does the proposed insured take any current medications, including preventative aspirin?  No  Yes Details:**

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

**(5) Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?**

- No  Yes Details: \_\_\_\_\_

**(6) Does the proposed insured engage in any regular exercise or sporting activity?**

- No  Yes Details: \_\_\_\_\_

**(7) Are there any other conditions that may impact life underwriting? If yes, please describe: \_\_\_\_\_**

\_\_\_\_\_