

HEART DISEASE—ABNORMAL EKG QUESTIONNAIRE

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) Which of the following tests have been done? Please provide the date(s) for each:

- | | |
|---|---|
| <input type="checkbox"/> Resting EKG Date(s): _____ | <input type="checkbox"/> Stress EKG Date(s): _____ |
| <input type="checkbox"/> Thallium Stress EKG Date(s): _____ | <input type="checkbox"/> Stress Echocardiogram Date(s): _____ |
| <input type="checkbox"/> Coronary Catheterization Date(s) _____ | <input type="checkbox"/> Coronary Angiography Date(s): _____ |
| <input type="checkbox"/> Other: _____ | |

(2) If a stress EKG was done, was it considered:

- Normal
 Borderline
 Mildly Abnormal
 Moderately abnormal
 Strongly abnormal

(3) Has the proposed insured had any of the following?

- Chest pain (angina) - include dates: _____
 Heart attack - include date(s): _____
 Angioplasties - include date(s) and number of vessels involved: _____
 Bypass surgery date: _____ Vessel used for the graft: _____ No. of vessels involved: _____

(4) Please advise if the proposed insured as been diagnosed with the following conditions:

- Elevated Cholesterol - most recent known level(s): Total: _____ LDL: _____ HDL: _____ Triglycerides: _____
 Uncontrolled high blood pressure - most recent reading: _____
 Overweight - current height and weight: _____
 Diabetes - age of onset: _____ Recent A1C test result: _____ (also, please ask us for our Diabetes Questionnaire)
 Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
 Other: _____

(5) 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

(6) Are there any other conditions that may impact life underwriting? If yes, please describe:
