

**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 **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

### FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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: \_\_\_\_\_
- Coronary angioplasty (PTCA) Date: \_\_\_\_\_
- Heart failure Date: \_\_\_\_\_
- Valve surgery Date: \_\_\_\_\_
- Bypass surgery Date: \_\_\_\_\_

4. Has client had any of the following?:

- Abnormal lipid levels  Diabetes
- Overweight  Elevated homocysteine
- High blood pressure  Peripheral vascular disease
- Irregular heart beats  Cerebrovascular or carotid disease
- Elevated cholesterol

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

(Accurate) Name of Medication	Dosage	Reason

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