HEART DISEASE—AORTIC REGURGITATION QUESTIONNAIRE

Agent: __________________________ Phone: __________________________ Fax: __________________________

Proposed Insured Name: __________________________ Date of Birth: __________________________
Face Amount: __________________________ Max. Premium: $__________/year UL WL Term Survivorship

Do you currently smoke cigarettes? ☐ Y ☐ N If no, did you ever smoke? ☐ Never ☐ Quit (Date): __________________________

Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): ☐ Y ☐ N
If Yes, please provide details: __________________________

When did you last use any form of tobacco: (Month) (Year) Type used last: __________________________

(1) Date of diagnosis: __________________________

(2) Have you been diagnosed or have you experienced any of the following:

☐ Light headedness ☐ Breathlessness ☐ Blackouts ☐ Aortic stenosis ☐ Coughing up blood
☐ Rheumatoid arthritis ☐ Syphilis ☐ Ankylosig spondylitis ☐ Marfan’s syndrome ☐ Edema
☐ Elevated Cholesterol - most recent known levels: Date: _______ LDL _______ HDL ________ Triglycerides ________
☐ High blood pressure - most recent reading(s): __________________________
☐ 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: __________________________

(3) Provide dates if any of the following tests or procedures (a) have been done or (b) have been recommended to be done?

☐ Resting EKG: __________________________ ☐ Stress EKG: __________________________
☐ Thallium Stress EKG: __________________________ ☐ Echocardiogram: __________________________
☐ Coronary Catheterization: __________________________ ☐ Stress Echocardiogram: __________________________
☐ Valve replacement surgery - which valves: __________________________
☐ Angioplasty - what specific type? (e.g. balloon...) __________________________
☐ Bypass Surgery: __________________________ Number of vessels involved: __________________________
☐ Other: __________________________

(4) Does the proposed insured take any current medications, including 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: __________________________

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