HEART DISEASE—CARDIOMYOPATHY QUESTIONNAIRE

Agent:                                                                                                      Phone:                                      Fax:

Proposed Insured Name: ___________________________________________ ☐ M ☐ F 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) The condition has been diagnosed as:
☐ Dilated cardiomyopathy                                      ☐ Hypertrophic cardiomyopathy
☐ Myocarditis                                                ☐ Idiopathic hypertrophic subaortic stenosis
☐ Myocardial fibrosis                                        ☐ Alcoholic cardiomyopathy
☐ Myocardial degeneration                                    ☐ Peripartum cardiomyopathy
☐ Congestive cardiomyopathy                                  ☐ Restrictive cardiomyopathy
☐ Other: ____________________________________________________

(3) Provide dates if any of the following tests or procedures have been done to evaluate the condition?
☐ Resting EKG: ___________________    ☐ Stress EKG:
☐ Thallium Stress EKG: __________    ☐ Echocardiogram:
☐ Holter Monitor: __________________☐ Chest X-ray: ______________
☐ Other: __________________________

(4) Is there any family history of heart disease or premature death due to heart disease?

<table>
<thead>
<tr>
<th></th>
<th>Age (if living)</th>
<th>History of heart disease?</th>
<th>Age at death:</th>
<th>Cause of death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(5) 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: __________________________

______________________________________________________________

______________________________________________________________