HEART DISEASE—MITRAL VALVE PROLAPSE 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) Have you been diagnosed or have you experienced any of the following:
☐ Light headedness ☐ Breathlessness ☐ Blackouts ☐ Mitral regurgitation ☐ Mitral stenosis
☐ Rheumatoid arthritis ☐ Syphilis ☐ Ankylosis spondylitis ☐ Barlow’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: _______ (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:

<table>
<thead>
<tr>
<th>Name of Medication (Prescription or Otherwise)</th>
<th>Dates Used</th>
<th>Quantity Taken</th>
<th>Frequency Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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: ____________________________________________________________

________________________________________________________________________________________________________________________