

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

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?

- Please check type of BBB present:
 CLBBB CRBBB LAHB or LPHB IRBBB Bifascicular block
- How long has this abnormality been present? _____ (years)
- Has there been any recent change in the ECG? No Yes; please give details

- Please check if your client has had any of the following: (check all that apply)
 - Chest pain or coronary artery disease
 - Cardiomyopathy
 - High blood pressure
 - Congenital heart disease
 - Valvular heart disease

- Have any cardiac studies been completed?
 - Exercise treadmill or thallium: No Yes—normal Yes—abnormal
 - Resting or exercise echocardiogram: No Yes—normal Yes—abnormal
 - Other: No Yes—normal Yes—abnormal

- Is your client on any medications? (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

- Does your client have any other major health problems? (ex: cancer, etc.) No Yes; please give details