

Underwriting Questionnaire

Cardiac Disease



Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

☐ Male ☐ Female Face Amount _____ Max Premium \$ _____ /yr.

☐ Term ☐ Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency _____ Date of last use _____ Type _____

Has the client had a heart attack? ☐ Yes ☐ No
If yes, provide date _____

Provide dates if any of the following tests have been completed

<input type="checkbox"/> Resting EKG _____	<input type="checkbox"/> Stress test _____
<input type="checkbox"/> Stress thallium _____	<input type="checkbox"/> Echocardiogram _____
<input type="checkbox"/> Stress echo _____	<input type="checkbox"/> EBCT (CT of the heart) _____
<input type="checkbox"/> Other _____	

Provide dates and results of any surgical procedures

<input type="checkbox"/> Bypass (CABG) _____
<input type="checkbox"/> Angioplasty (PTCA) _____
<input type="checkbox"/> Coronary artery stents _____

How many vessels are involved ☐ 1 ☐ 2 ☐ 3 or more Which vessels _____

What conditions has the client been diagnosed with

<input type="checkbox"/> Diabetes Age of onset _____	Recent A1c result _____
<input type="checkbox"/> High blood pressure Most recent reading _____	
<input type="checkbox"/> Irregular heartbeat	
<input type="checkbox"/> Other arterial disease <input type="checkbox"/> Carotid <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Cerebrovascular	

Does the client take any current medications, including preventative aspirin ☐ Yes ☐ No

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

Does the client engage in any regular exercise or sporting activity ☐ Yes ☐ No If yes, provide details _____

List any other major health problems the client has: _____