

**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 UL

**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?

1. Please check type of BBB present:

CLBBB  CRBBB  LAHB or LPHB  IRBBB  Bifascicular block

2. How long has this abnormality been present? \_\_\_\_\_ (years)

3. Has there been any recent change in the ECG?

No  Yes; please give details \_\_\_\_\_

4. 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

5. Have any cardiac studies been completed?

- a. Exercise treadmill or thallium:  No  Yes—normal  Yes—abnormal
- b. Resting or exercise echocardiogram:  No  Yes—normal  Yes—abnormal
- c. Other:  No  Yes—normal  Yes—abnormal

6. Is your client on any medications? (accurate name, dosage, and reason): \_\_\_\_\_

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