

**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. Date the pacemaker was implanted: \_\_\_\_\_

2. The pacemaker was implanted for:

- Heart block associated with coronary artery disease
- Complete heart block or sick sinus syndrome
- Chronic underlying atrial flutter/fibrillation
- Other; give details \_\_\_\_\_

3. Does client have another heart disease? Give details:

\_\_\_\_\_

4. Have any of the following pacemaker complications occurred?

- Infection  Blood clots  Pacemaker malfunction  Perforation
- Other; please give details \_\_\_\_\_

5. Are there any continuing symptoms since the pacemaker was implanted?  No  Yes; please give details

\_\_\_\_\_

6. When was client's last checkup? \_\_\_\_\_

7. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

8. Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details

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