ATRIAL FIBRILLATION

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 ☐ Disability **Coverage Amount:** _____

Annual Income:_____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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 of first diagnosis: _____

2. Is the atrial fibrillation/flutter: ☐ Chronic (permanent) ☐ Proxysmal (intermittent)

3. Are there any symptoms with the irregular heart beat?

☐ Black-out ☐ Dizziness (light-headedness)/faint feeling

☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:

☐ ECG _____

☐ Stress test _____

☐ Echocardiogram _____

☐ Holter monitor _____

5. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

6. The cause of the atrial fibrillation/flutter is due to:

☐ Coronary heart disease ☐ Alcohol

☐ Thyroid disease ☐ Cardiomyopathy

☐ Mitral valve disease ☐ Unknown

☐ Other, give details _____

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

_____

_____

_____

