MITRAL VALVE DISORDER

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. How long has this abnormality been present? _____

2. Please check the type(s) of valve disorder present:

☐ Mitral stenosis ☐ Mitral regurgitation ☐ Mitral valve prolapse

3. Have any of the following occurred?

Chest pain ☐ No ☐ Yes

Trouble breathing ☐ No ☐ Yes

Heart failure ☐ No ☐ Yes

Palpitations ☐ No ☐ Yes

Atrial fibrillation/flutter ☐ No ☐ Yes

4. Is there a history of any other heart disease in addition to the mitral valve disorder (problems with other valves, coronary artery disease, etc.)? ☐ No ☐ Yes; please give details

_____

_____

5. Have additional studies been completed? (check all that apply)

☐ Echocardiogram Date: _____

☐ Cardiac catheterization Date: _____

☐ None

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

