T WAVE CHANGES

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. Has there been any recent change in the ECG (last 12 month)? ☐ No ☐ Yes; please give details

_____

_____

3. Please check if your client has had any of the following: (check all that apply)

a) Chest pain, coronary artery disease, or other cardiovascular impairment ☐ No ☐ Yes; please give details

_____

_____

b) diabetes ☐ No ☐ Yes

c) elevated cholesterol ☐ No ☐ Yes

d) high blood pressure ☐ No ☐ Yes

4. Have any other studies been completed?

a) exercise treadmill or thallium: ☐ No ☐ Yes, normal ☐ Yes, abnormal

b) resting or exercise echocardiogram: ☐ No ☐ Yes, normal ☐ Yes, abnormal

5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

