

Client Name: _____ Date of Birth: _____

 Gender: Male Female Height: _____ Weight: _____

 Tobacco Usage: Never Former Current Date Stopped: _____ Type: _____
 Coverage Information: Type: Term UL IUL WL VUL Survivorship
 Face Amount: _____ Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. List the date(s) of diagnosis: _____

2. Type of Coronary Artery Disease: _____

 3. Does the client's family have a history of heart disease? No Yes, list family members and details

 4. Has the client had either of the following?

Bypass Surgery:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Coronary Angioplasty:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Heart Attack:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Heart Failure:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____
Valve Surgery:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, date: _____

 5. Has the client had any of the following?

<input type="checkbox"/> Abnormal lipid levels	<input type="checkbox"/> Carotid Disease	<input type="checkbox"/> Cerebrovascular Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Elevated Homosysteine	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Overweight	<input type="checkbox"/> Peripheral Vascular Disease

 6. Please list current medications:

Name of Medication	Dosage	Reason

 7. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____