

Agent Name: \_\_\_\_\_ Agent Phone: \_\_\_\_\_ Agent Email: \_\_\_\_\_

**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. When was the surgery completed? \_\_\_\_\_

2. Please note type of valve surgery:  
 Valve replacement  Valvuloplasty  
 Commissurotomy  Other \_\_\_\_\_

3. Please check the type (s) of valve disorder:  
 Aortic stenosis  Mitral stenosis  Mitral valve prolapse  
 Aortic insufficiency  Mitral insufficiency

4. Please note type of valve used if replaced:  
 Prosthetic (mechanical)  Tissue (porcine or pig)

5. Have any of the following occurred?  
 Chest pain  Heart failure  Palpitations  Dizziness/fainting  Trouble breathing

6. Is there a history of any other disease in addition to the valve disorder (coronary artery disease, etc.)?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

7. Is client taking any medication, including inhalers? (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

\_\_\_\_\_

\_\_\_\_\_

***The above information is for preliminary underwriting purposes only and will not be made part of any contract.***