Underwriting Questionnaire

Angina (Chest Pain)



Producer Name	Phone	Date	
Client Name	Date of Birth		
☐ Male ☐ Female Face Amount		Max Premium \$	/yr.
☐ Term ☐ Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No			
Frequency	Date of last use	Ту	pe
If your client has had chest pain or angina, please answer the following:			
Date of first occurrence			
Is the client on any medications (including a Yes (details) No			
Has the client had any of the following test (check all that apply) Angiography MUGA Scan Resting EKG Stress Echocardiogram	EKG m Stress EKG	Check if the client has had any Abnormal Lipid Level Diabetes Elevated Homocystei	s Family History of Heart Disease High Blood Pressure
Provide the dates and details for the following (if applicable)			
Heart Attack(s)			
Bypass Surgery(s)			
Number of Vessels			
Angioplasty(s)			
Number of Vessels			
List any other major health problems the client has:			

Please submit the actual tracings and results of all stress electrocardiograms and any further testing if done (thallium, echo, or angiogram).



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