

# Underwriting Questionnaire

## Atrial Fibrillation



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 \_\_\_\_\_ Type \_\_\_\_\_

Age/date when first diagnosed \_\_\_\_\_  Chronic (permanent)  Paroxysmal (intermittent)

Current medications \_\_\_\_\_

What is the cause of the atrial fibrillation? \_\_\_\_\_

Average number of episodes per year \_\_\_\_\_ Date of last episode \_\_\_\_\_

Has the client ever had an ablation procedure? If yes, please advise date \_\_\_\_\_

Has the client ever had a cardioversion? If yes, please advise date \_\_\_\_\_

Does the client have a pacemaker or defibrillator implanted? If yes, please advise:

Type \_\_\_\_\_ Date of implant \_\_\_\_\_

Does the client have

High blood pressure, reading(s) \_\_\_\_\_ Date \_\_\_\_\_

High cholesterol, total cholesterol \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ Ratio \_\_\_\_\_ Date \_\_\_\_\_

Have any of the following tests been done

|   | Date(s) | Results |
|---|---------|---------|
| <input type="checkbox"/> EKG            | _____   | _____   |
| <input type="checkbox"/> Stress test    | _____   | _____   |
| <input type="checkbox"/> Echocardiogram | _____   | _____   |
| <input type="checkbox"/> Holter monitor | _____   | _____   |
| <input type="checkbox"/> Other          | _____   | _____   |

List any other major health problems the client has: