

# Underwriting Questionnaire

## Blood Clots



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 \_\_\_\_\_

### Cause of blood clot

- Atrial Fibrillation  Travel  Sedentary Lifestyle  
 PFO (Patent Foramen Ovale)  ASD (Atrial Septal Defect)  Post-Operative Complication  
 Other \_\_\_\_\_

### Clotting Disorder

- Factor V Leiden Resistance  Lupus Anticoagulant  Antiphospholipid Antibody  
 Other \_\_\_\_\_

Date of first diagnosis \_\_\_\_\_

### Type of treatment

- Blood thinner (coumadin); date(s) \_\_\_\_\_  
 Aspirin; date(s) \_\_\_\_\_  
 Hospitalization; date(s) \_\_\_\_\_

Any evidence of recurrence  Yes  No If yes, provide dates/details \_\_\_\_\_

### Have any of the following occurred due to blood clots

- Heart attack  Stroke  Deep vein thrombosis (DVT)  Pulmonary embolism  
 Other \_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: