Underwriting Questionnaire

Peripheral Vascular Disease



Producer Name	Phone		Date	_ \
Client Name	Date of Birth	1		
☐ Male ☐ Female Face Amount		Max Premium :	\$ /yr	
☐ Term ☐ Permanent Has the clier	nt ever used any form of	tobacco (cigarettes, o	cigars, pipe, snuff, etc	:.)? □Yes □No
Frequency	Date of last use _		Type	
Date of diagnosis	Artery(s) involved			
Location				
Select the treatments the client has had Angioplasty; date Bypass grafting; date				
Are any of the following present (select all th ☐Bruit heard by physician ☐Claudication pain with activity	☐ Diminished		tio (if yes, send copy o	f results)
Has the client had any of the following (selec ☐Abnormal lipid levels ☐Chest pain	t all that apply) □Diabetes □Coronary ar	tery disease		ood pressure vascular or carotid disease
Name of Medication (prescription or ot	herwise) D	ates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:



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