

Underwriting Questionnaire

Peripheral Vascular Disease



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 _____

Date of diagnosis _____ Artery(s) involved _____

Location
 Legs Arms

Select the treatments the client has had
 Angioplasty; date _____
 Bypass grafting; date _____

Are any of the following present (select all that apply)
 Bruit heard by physician Diminished pulses
 Claudication pain with activity Ankle - brachial blood pressure ratio (if yes, send copy of results)

Has the client had any of the following (select all that apply)
 Abnormal lipid levels Diabetes High blood pressure
 Chest pain Coronary artery disease Cerebrovascular or carotid disease

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

List any other major health problems the client has: