Underwriting Questionnaire | Atrial Fibrillation

Underwriting

Financial Professional Information

Name:_____ Phone: _____ Date:_____

Client Information

Name:_____ Date of Birth: _____ State of Residence:_____

☐ Male ☐ Female Height:____ft.____in. Weight:____lbs.

Face Amount:_____ Max Premium $_____/yr.

Desired Life Insurance Type: ☐ 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
☐ EKG		
☐ Stress test		
☐ Echocardiogram		
☐ Holter monitor		
☐ Other		

List any other major health problems the client has:

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