BackNine Insurance

QUICK QUOTE FOR HEART CONDITIONS

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

CLIENT: NAME _____ / ❑ M ❑ F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS. ❑ UL ❑ TERM YRS. LVL _____

TOBACCO USE ❑ NO ❑ YES, TYPE _____ / REPLACEMENT? ❑ YES ❑ NO / CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

FAMILY HISTORY: AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____

DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK ❑ NO ❑ YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____/_____ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. THE CLIENT'S HEART CONDITION / DIAGNOSIS IS:

❑ HEART MURMUR: TYPE _____ GRADE _____
❑ CARDIOMYOPATHY:
TYPE: ❑ CONGESTIVE
❑ RESTRICTIVE
❑ ASYMMETRIC SEPTAL HYPERTROPHY
❑ IDIOPATHIC HYPERTROPHY SUB-AORTIC STENOSIS
❑ CARDIAC ENLARGEMENT / LEFT VENTRICLE HYPERTROPHY
❑ ARRYTHMIAS:
TYPE _____
❑ CONGESTIVE HEART FAILURE
❑ CHEST PAINS
❑ OTHER _____

2. DATE DIAGNOSED _____ DATE RESOLVED _____

3. ARE THERE ANY CURRENT SYMPTOMS?

❑ NO ❑ YES, PLEASE DETAIL _____

_____

_____

4. WHAT TREATMENTS HAVE BEEN PRESCRIBED?

❑ MEDICATIONS, PLEASE LIST _____

_____

❑ PACEMAKER, START DATE _____

❑ SURGERY, PLEASE DETAIL TYPE AND DATE _____

_____

5. DOES CLIENT WORK FULLTIME? ❑ YES ❑ NO

6. WHAT TESTS HAVE BEEN PERFORMED?

❑ RESTING EKG
DATE AND RESULTS _____
❑ EXERCISE EKG
DATE AND RESULTS _____
❑ THALLIUM TEST
DATE AND RESULTS _____
❑ STRESS ECHOCARDIOGRAM
DATE AND RESULTS _____
❑ CORONARY CATHETERIZATION
DATE AND RESULTS _____

7. WHAT IS THE EJECTION FRACTION? _____

8 LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

_____

_____

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