



# EMG Insurance Brokerage

## HEART DISEASE CONGESTIVE HEART FAILURE QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of birth: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_ / year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):  Y  N

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: \_\_\_\_ (Month) \_\_\_\_ (Year) Type used last: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

(1) *Date of diagnosis:* \_\_\_\_\_

(2) *The condition has been diagnosed that has lead to the Congestive Heart Failure?*

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Heart valve disease                |
| <input type="checkbox"/> Irregular heart beats            | <input type="checkbox"/> Congenital heart valve abnormality |
| <input type="checkbox"/> Atrial fibrillations             | <input type="checkbox"/> Hyperthyroidism                    |
| <input type="checkbox"/> Ventricular fibrillations        | <input type="checkbox"/> Myocarditis                        |
| <input type="checkbox"/> Cardiomyopathy                   | <input type="checkbox"/> Peripheral edema                   |
| <input type="checkbox"/> Other: _____                     |   |

(3) *Provide dates if any of the following tests or procedures have been done to evaluate the condition?*

- |   |  |
|---|--|
| <input type="checkbox"/> Resting EKG: _____         | <input type="checkbox"/> Stress EKG: _____     |
| <input type="checkbox"/> Thallium Stress EKG: _____ | <input type="checkbox"/> Echocardiogram: _____ |
| <input type="checkbox"/> Holter Monitor: _____      | <input type="checkbox"/> Chest X-ray: _____    |
| <input type="checkbox"/> Other: _____               |  |

(4) *Please provide the Ejection Fraction (EF) of the most recent stress echocardiogram:* \_\_\_\_\_ %

(5) *Is there any family history of heart disease or premature death due to heart disease?*

	Age (if living)	History of heart disease?	Age at death:	Cause of death:
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sister(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brother(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(6) *Does the proposed insured take any current medications?*  No  Yes Details:

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

(7) *Are there any other conditions that may impact life underwriting?* If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_