



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 pacemaker implant:* \_\_\_\_\_

(2) *What is the reason for the pacemaker implant?* \_\_\_\_\_

(3) *Provide dates if any of the following tests or procedures have been done:*

- Resting EKG: \_\_\_\_\_  Stress EKG: \_\_\_\_\_
- Thallium Stress EKG: \_\_\_\_\_  Echocardiogram: \_\_\_\_\_
- Holter Monitor: \_\_\_\_\_  Chest X-ray: \_\_\_\_\_
- Other: \_\_\_\_\_

(4) *Has the proposed insured been diagnosed as having any of the following:*

- Bradycardia  Cardiomyopathy
- Paroxysmal atrial fibrillation  Congenital heart block without other heart disorder
- Chronic atrial fibrillation  Congenital heart block with other heart disorder
- Sick sinus syndrome  Heart block associated with coronary artery disease
- Atrial flutter  Heart block  First Degree  Second Degree  Third Degree
- Other: \_\_\_\_\_

(5) *Are there any current symptoms of any heart disease? If yes, check all that apply:*

- Dizziness or light headedness  Black outs
- Chest pain  Palpitations
- Other: \_\_\_\_\_

(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: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_