## **Underwriting Questionnaire**

## **Atrial Fibrillation**



Producer Name		Phone	Dat	e	
Client Name		Date of Birth		_	
☐ Male ☐ Female F	ace Amount		Max Premium \$	/yr.	
☐ Term ☐ Permanent	Has the client eve	er used any form of t	cobacco (cigarettes, cigars, p	oipe, snuff, etc.)? □Yes □No	
Frequency		Date of last use		Type	
Age/date when first diagnose	d		Chronic (permanent)	Paroxysmal (intermittent)	
Current medications					
What is the cause of the atria	l fibrillation?				
Average number of episodes	per year	Date of last e	pisode		
Has the client ever had an abl	ation procedure? If	yes, please advise da	te		
Has the client ever had a card	ioversion? If yes, ple	ase advise date			
Does the client have a pacem	aker or defibrillator i	mplanted? If yes, ple	ease advise:		
			nt		
Does the client have					
High blood pressure	, reading(s)			Date	
High cholesterol, tot	al cholesterol	HDL	_ LDL Rat	io Date	
Have any of the following tes	ts been done				
	Date(s)	Res	sults		
EKG					
Stress test					
Echocardiogram					
Holter monitor					
Other					

List any other major health problems the client has:



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