# ATRIAL FIBRILLATION

**CLIENT NAME:** _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

**Tobacco Use:** ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

**Type of Coverage:** ☐ Term ☐ UL ☐ Survivor **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL

**Coverage Amount:** _____ **Anticipated Premium:** _____

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?

***If yes, use separate sheet to provide this information, including age of onset and date of death***

| PROPOSED INSURED'S EXISTING INSURANCE | | | |
|---|---|---|---|
| Full Name of Company | Face Amount | Year Issued | Is Policy to be Replaced? |
| | | | |
| | | | |

1. Date of first diagnosis: _____

2. Is the atrial fibrillation/flutter: ☐ Chronic (permanent) ☐ Proxysmal (intermittent)

3. Are there any symptoms with the irregular heart beat?

☐ Black-out ☐ Dizziness (light-headedness)/faint feeling

☐ Palpitations ☐ Chest discomfort

4. Have any of the following tests been done? If so, please give date and results:

☐ ECG _____

☐ Stress test _____

☐ Echocardiogram _____

☐ Holter monitor _____

5. Please list current medications (including aspirin), (accurate name, dosage, and reason):

| (Accurate) Name of Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |

6. The cause of the atrial fibrillation/flutter is due to:

☐ Coronary heart disease ☐ Alcohol

☐ Thyroid disease ☐ Cardiomyopathy

☐ Mitral valve disease ☐ Unknown

☐ Other, give details _____

7. Are there any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

_____

 