

T WAVE CHANGES

CLIENT NAME:			Date:		
\square Male \square Female Date of birth: _	Heigl	nt:""	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 Amo		1	Year Issued Is Policy to be Replaced?		
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1. How long has this abnormality been present?					
2. Has there been any recent change in the ECG (last 12 month)? ☐ No ☐ Yes; please give details					
2. That there been any recent entange in the Loca (hast 12 month).					
3. Please check if your client has had any of the following: (check all that apply)					
a) Chest pain, coronary artery disease, or other cardiovascular impairment \square No \square Yes; please give details					
b) diabetes					
c) elevated cholesterol					
d) high blood pressure					
4. Have any other studies been completed?					
a) exercise treadmill or thallium: \square No \square Yes, normal \square Yes, abnormal					
b) resting or exercise echocardiogram: \square No \square Yes, normal \square Yes, abnormal					
5. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)					
5. Is client taking any medication, including initalets? (accurate name, dosage, and reason)					
(Accurate) Name of Medication		Dosage	Reason		
6. Are there any other health problems? (additional questionnaires may be required) 🔲 No 🖂 Yes; please give details					