

# Underwriting Questionnaire

## Pacemaker



Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.

Term  Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Date of pacemaker implant \_\_\_\_\_

Reason for the implant \_\_\_\_\_

Provide dates if any of the following tests have been completed

- |                                                    |                                               |
|----------------------------------------------------|-----------------------------------------------|
| <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 _____               |                                               |

Has the client been diagnosed as having any of the following

- |                                                         |                                                                                       |
|---------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> Bradycardia                    | <input type="checkbox"/> Cardiomyopathy                                               |
| <input type="checkbox"/> Paroxysmal atrial fibrillation | <input type="checkbox"/> Congenital heart block without other heart disorder          |
| <input type="checkbox"/> Chronic atrial fibrillation    | <input type="checkbox"/> Congenital heart block with other heart disorder             |
| <input type="checkbox"/> Sick sinus syndrome            | <input type="checkbox"/> Heart block associated with coronary artery disease          |
| <input type="checkbox"/> Atrial flutter                 | <input type="checkbox"/> Heart block ___First Degree ___Second Degree ___Third Degree |
| <input type="checkbox"/> Other _____                    |                                                                                       |

Are there any current symptoms of any heart disease (select all that apply)

- |                                                        |                                       |
|--------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dizziness or light headedness | <input type="checkbox"/> Blackouts    |
| <input type="checkbox"/> Chest pain                    | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Other _____                   |                                       |

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: