HEART CONDITIONS QUESTIONNAIRE

Global Insurance Resources Group Inc.

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CLIENT: NAME ________________________________ [ ] M [ ] F, DATE OF BIRTH ___________

AGE_____ HT _____ WT_____ STATE _______

AMOUNT REQ. $____________ MAX. ANNUAL PREMIUM $___________

TYPE OF INSURANCE: [ ] PERM [ ] TERM YRS. LEVEL _______

TOBACCO USE: [ ] NO [ ] YES, DETAIL__________________________

REPLACING? [ ] NO [ ] YES CURRENT ANN. PREM. $ __________

LAST LIFE INSURANCE APP. YEAR:_______ COMPANY______________________________
ACTION____________________________

AGENT: NAME________________________ PHONE______________FAX_______________

ADDRESS______________________________ CITY____________ ST_______ ZIP ________

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1. THE CLIENT'S HEART CONDITION / DIAGNOSIS IS:
[ ] HEART MURMUR:
TYPE _________________________________
GRADE ______________

[ ] CARDIMYOPATHY, TYPE:
[ ] CONGESTIVE
[ ] RESTRICTIVE
[ ] ASYMMETRIC SEPTAL HYPERTROPHY
[ ] IDIOPATHIC HYPERTROPHY SUB-AORTIC STENOSIS
[ ] CARDIAC ENLARGEMENT OR LEFT VENTRICLE HYPERTROPHY
[ ] ARRHYTHMIA, TYPE ___________________
[ ] CONGESTIVE HEART FAILURE
[ ] CHEST PAINS
[ ] OTHER _______________________________

2. DATE DIAGNOSED ________________
DATE RESOLVED ______________

3. ARE THERE ANY CURRENT SYMPTOMS?
[ ] NO [ ] YES, PLEASE DE__________________

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5. CLIENT'S OCCUPATION ___________________

IS IT FULL-TIME WORK? [ ] YES [ ] NO

6. WHAT TEST HAVE BEEN PERFORMED?
[ ] RESTING EKG,
DATE AND RESULTS ______________________

[ ] EXERCISE EKG,
DATE AND RESULTS ______________________

[ ] THALLIUM TEST
DATE AND RESULTS ______________________

[ ] STRESS ECHOCARDIOGRAM
DATE AND RESULTS ______________________

[ ] CORONARY CATHETERIZATION
DATE AND RESULTS ______________________

[ ] EJECTION FRACTION DATE AND RESULTS
____

7. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?
[ ] NO [ ] YES, PLEASE DETAIL ______________

4. WHAT TREATMENTS HAVE BEEN PRESCRIBED?
[ ] MEDICATIONS, IF YES, PLEASE LIST;
____

____

[ ] PACEMAKER, IF YES, START DATE__________

[ ] SURGERY, IF YES PLEASE DETAIL TYPE AND DATE__________
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8. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?
[ ] NO [ ] YES, PLEASE DETAIL
____

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9. PLEASE LIST ANY OTHER IMPAIRMENTS OR ILLNESSES ; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:
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