Cardiac / Atrial Fibrillation Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured diagnosed with Atrial Fibrillation? _____

2. Has the proposed insured been diagnosed with: ___ Chronic Atrial Fibrillation ___ Paroxysmal Atrial Fibrillation

3. What is the underlying cause of the Atrial Fibrillation? (Check all that apply)

___ High blood pressure ___ Coronary artery disease ___ Cardiomyopathy
___ Heart valve disease ___ Having undergone heart surgery ___ Chronic lung disease
___ Heart failure ___ Congenital heart disease ___ Pulmonary embolism
___ Hyperthyroidism ___ Pericarditis ___ Viral infection
___ Other: _____

4. Has the proposed insured had any of the following symptoms?

___ Chest discomfort Date: _____ or ___ currently experiences
___ Black-out Date: _____ or ___ currently experiences
___ Palpitations Date: _____ or ___ currently experiences
___ Dizziness/faint feeling Date: _____ or ___ currently experiences

5. Has the proposed insured ever had any of the following procedures?

___ Electrical Cardioversion Date: _____
___ Ablation Date: _____
___ Pulmonary vein antrum isolation Date: _____
___ Implantation of a defibrillator or pacemaker Date: _____

6. Is the proposed insured taking any medication(s)? ___ Yes ___ No
If yes, provide name, dosage and frequency of medication(s): _____
_____
_____
_____

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