Cardiomyopathy 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? ____________________

2. The condition was diagnosed as:

   ___ Dilated Cardiomyopathy
   ___ Hypertrophic Cardiomyopathy
   ___ Restrictive Cardiomyopathy
   ___ Other: ____________________

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

   ___ Chest pain or pressure
   ___ Swelling of lower extremities
   ___ Palpitations
   ___ Shortness of breath
   ___ Weight gain
   ___ Dizziness
   ___ Fatigue
   ___ Fainting

4. Has the proposed insured Undergone any of the following procedures?

   ___ Pacemaker Date: ________
   ___ Implantable cardioverter defibrillator Date: ________
   ___ Other: ____________________ Date: ________

5. Is there a family history of heart disease? ___ Yes ___ No
   If yes, provide relationship to proposed insured and date of onset and/or death: ____________________

6. Is the proposed insured taking any medication? ___ Yes ___ No
   If yes, provide name, dosage and frequency: ____________________

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