



Abnormal EKG Questionnaire

Agent: _____ Phone: _____ Fax: _____
Client: _____ DOB : _____ Male Female
Product/Face Amount: _____ Height: _____ Weight: _____

* **TOBACCO/NICOTINE USE (past or present):** YES*** NO

***Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

* Please list the date of discovery, duration and the circumstance associated with identification of your EKG as “abnormal”:

* Are you aware of any specifics and/or are you able to provide other details as to the type of EKG abnormality?

YES – Description:

NO – Unaware of specifics

* Have you been told about any changes or evolution in the ECG abnormality since initial diagnosis?

YES – Description of change(s):

NO – EKG abnormality remains stable to my knowledge.

* Does the proposed insured have a history of any of the following? (Complete appropriate questionnaire for all YES responses)

☞ **Cardiovascular Disease(s)*** YES NO

(*i.e. coronary artery disease, hypertension, structural/valvular heart disease, etc. vascular disease)

☞ **Diabetes** YES NO

☞ **Elevated cholesterol** YES NO

* Studies completed in response to ECG abnormality:

*Exercise treadmill, thallium “stress test”, etc.

YES - *NORMAL* result YES – *ABNORMAL* result *NONE*

*Echocardiogram

YES - *NORMAL* result YES – *ABNORMAL* result *NONE*

**Other* – Please describe, or list details of any prior abnormal studies:

* **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (parent or siblings) of the following conditions/disease onset prior to age 60:**

Cardiac Disease YES NO *Diabetes* YES NO
Stroke or TIA YES NO *Cancer* YES NO

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (if living)	DECEASED (list age @ time of death)
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

* **MEDICATIONS** - *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
<i>1.</i>		<i>5.</i>	
<i>2.</i>		<i>6.</i>	
<i>3.</i>		<i>7.</i>	
<i>4.</i>		<i>8.</i>	

* **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

Condition(s) - List treatment and current status:

NONE - NO other medical conditions or health issues.

* **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.**

* **Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**

*****If possible, submit a copy of the most recent electrocardiogram (EKG), along with any earlier EKGs that may be available.**