Underwriting Questionnaire **Atrial Fibrillation**



Producer Name		Phone	Date	<u> </u>	
Client Name		Date of Birth _		_	
☐ Male ☐ Female Face	Amount		Max Premium \$	/yr.	
☐ Term ☐ Permanent	Has the client ever u	used any form of to	obacco (cigarettes, cigars, p	ipe, snuff, etc.)? □Yes □No	
Frequency		ate of last use		Type	
Age/date when first diagnosed_			Chronic (permanent)	Paroxysmal (intermittent)	
Current medications					
What is the cause of the atrial fib	orillation?				
Average number of episodes per	year	Date of last ep	isode		
Has the client ever had an ablatic	on procedure? If yes,	, please advise dat	e		
Has the client ever had a cardiove	ersion? If yes, please	advise date			
Does the client have a pacemake Type			ase advise: nt		
Does the client have					
	-			Date D Date	
Have any of the following tests b	een done				
_	Date(s)	Res	ults		
EKG					
Stress test					
☐ Echocardiogram					
Holter monitor					
Other					

List any other major health problems the client has:

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