Underwriting Questionnaire **Blood Clots**

| Producer Name | | Phone | | Date | |
|--|----------------------|-------------------|----------------------------------|----------------------------|-----------------|
| Client Name | | _ Date of Birth | | | |
| □ Male □ Female Face Amount | | Max Premium \$ | | /yr. | |
| □ Term □ Permanent Has the o | client ever used any | form of tobacco (| cigarettes, cigars, p | pipe, snuff, etc.)? | □Yes □No |
| Frequency | Date of last u | | | | |
| PFO (Patent Foramen Ovale) | | | □Sedentary Lif □Post-Operativ | festyle ve Complication | |
| Clotting Disorder | | 5 | Antiphospholipid Antibody | | |
| Date of first diagnosis | | | | | |
| Type of treatment Blood thinner (coumadin); date(Aspirin; date(s) Hospitalization; date(s) | , | | | | |
| Any evidence of recurrence Yes No If yes, provide dates/details | | | | | |
| Have any of the following occurred due to Heart attack Stroke | Deep vein thr | | □Pulmonary e | mbolism | |
| Name of Medication (prescription o | r otherwise) | Dates Used | Quai | ntity Taken | Frequency Taken |
| | | | | | |
| | | | | | |

List any other major health problems the client has:

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