

Underwriting Questionnaire

Blood Clots

Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

Male Female Face Amount _____ Max Premium \$ _____ /yr.

Term Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Cause of blood clot

- Atrial Fibrillation Travel Sedentary Lifestyle
- PFO (Patent Foramen Ovale) ASD (Atrial Septal Defect) Post-Operative Complication
- Other _____

Clotting Disorder

- Factor V Leiden Resistance Lupus Anticoagulant Antiphospholipid Antibody
- Other _____

Date of first diagnosis _____

Type of treatment

- Blood thinner (coumadin); date(s) _____
- 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 blood clots

- Heart attack Stroke Deep vein thrombosis (DVT) Pulmonary embolism
- Other _____

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: