Underwriting Questionnaire
Peripheral Vascular Disease

Truist Life Insurance Services

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 _____

Date of diagnosis _____ Artery(s) involved _____

Location
☐ Legs ☐ Arms

Select the treatments the client has had
☐ Angioplasty; date _____
☐ Bypass grafting; date _____

Are any of the following present (select all that apply)
☐ Bruit heard by physician
☐ Claudication pain with activity
☐ Diminished pulses
☐ Ankle - brachial blood pressure ratio ***(if yes, send copy of results)***

Has the client had any of the following (select all that apply)
☐ Abnormal lipid levels
☐ Chest pain
☐ Diabetes
☐ Coronary artery disease
☐ High blood pressure
☐ Cerebrovascular or carotid disease

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

List any other major health problems the client has: