

QUICK QUOTE Heart Conditions



Phoenix, AZ 85049-0187
 Phone: 602-494-9500/800-516-0283
FAX: 602-494-0500
 Email: info@lbiusa.com

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

CLIENT: NAME _____ / [] M [] F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____
 AMNT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. [] UL [] TERM YRS. LVL _____
 TOBACCO USE [] NO [] YES, TYPE _____ / REPLACEMENT? [] YES [] NO / CURRENT ANN. PREM. \$ _____
 LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____
 OCCUPATION _____ / MARITAL STATUS [] SINGLE [] MARRIED [] WIDOWED [] DIVORCED
 FAMILY HISTORY: AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____
 IF ANY DECEASED, GIVE RELATION(S), AGE(S) AND CAUSE(S) _____
 DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____
 DO YOU EXERCISE 3 OR MORE TIMES PER WEEK [] NO [] YES, DETAILS _____
 DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____
 LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE [] NO [] YES
 LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL [] NO [] YES
 AGENT: NAME _____ PHONE _____ FAX _____
 ADDRESS _____ CITY _____ ST _____ ZIP _____

<p>1. THE CLIENT'S HEART CONDITION/DIAGNOSIS IS: <input type="checkbox"/> HEART MURMUR: TYPE _____ GRADE _____ <input type="checkbox"/> CARDIOMYOPATHY: TYPE: <input type="checkbox"/> CONGESTIVE <input type="checkbox"/> RESTRICTIVE <input type="checkbox"/> ASYMMETRIC SEPTAL HYPERTROPHY <input type="checkbox"/> IDIOPATHIC HYPERTROPHY SUB-AORTIC STENOSIS <input type="checkbox"/> CARDIAC ENLARGEMENT/LEFT VENTRICLE HYPERTROPHY <input type="checkbox"/> ARRHYTHMIAS: TYPE: _____ <input type="checkbox"/> CONGESTIVE HEART FAILURE <input type="checkbox"/> CHEST PAINS <input type="checkbox"/> OTHER _____</p> <p>2. DATE DIAGNOSED _____ DATE RESOLVED _____</p> <p>3. ARE THERE ANY CURRENT SYMPTOMS? <input type="checkbox"/> NO [] YES, PLEASE DETAILS _____ _____</p> <p>4. WHAT TREATMENTS HAVE BEEN PRESCRIBED? <input type="checkbox"/> MEDICATIONS, PLEASE LIST _____ _____ <input type="checkbox"/> PACEMAKER START DATE _____ <input type="checkbox"/> SURGERY, PLEASE DETAILS TYPE AND DATE _____ _____</p>	<p>5. DOES CLIENT WORK FULL TIME? [] YES [] NO</p> <p>6. WHAT TESTS HAVE BEEN PERFORMED? <input type="checkbox"/> RESTING EKG DATE AND RESULTS _____ <input type="checkbox"/> EXERCISE EKG DATE AND RESULTS _____ <input type="checkbox"/> THALLIUM TEST DATE AND RESULTS _____ <input type="checkbox"/> STRESS ECHOCARDIOGRAM DATE AND RESULTS _____ <input type="checkbox"/> CORONARY CATHETERIZATION DATE AND RESULTS _____ <input type="checkbox"/> EJECTION FRACTION DATE AND RESULTS _____</p> <p>7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY: _____ _____ _____</p>
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