Atrial Fibrillation Questionnaire - Tentative offers obtained are not binding and could be subject to change – Final offers are subject to formal application and review of all required age/face requirements, paramedical requirements and review of complete medical records.

Agent/Advisor Name: _____
Proposed Insured: _____ Date Of Birth: _____ Gender: Male☐ or ☐Female
Build: Height_____ Weight_____ Any Weight Loss In Last Year? If so how much _____
Product Desired: Term ☐ Guarantee UL☐ Index UL☐ Whole Life☐Survivorship Life ☐
Face Amount Desired: Option 1 $_____ Option 2 $_____ Option 3$_____
Maximum Premium Tolerance Per Year: _____
Has Client Ever Used Any Form Of Nicotine? No ☐ Yes ☐
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Patch ☐ Nicorette Gum ☐ E-Cigarette ☐ Vape
Frequency: _____ Date Last Used_____
Current Alcohol Use: Type_____ Number of Drinks: _____ Per _____Day ____Week Date Last Used: _____

1) Date first diagnosed with atrial fibrillation? _____ Age at diagnosis? _____
2) Please indicate whether atrial fibrillation/flutter is: ☐Chronic (permanent) or ☐Paroxysmal (intermittent)
   If paroxysmal; please specify how often it occurs:
   _____
3) Are there any symptoms with the irregular heart beat? ☐No ☐Yes If yes; provide details
   _____
4) What is the cause of your atrial fibrillation? ☐Coronary artery disease ☐Thyroid disease ☐Valve disease ☐Sick sinus syndrome ☐Hypertension ☐Cardiomyopathy ☐Alcohol ☐Unknown ☐Other
5) Have any of the following tests been done? If so please provide date and results
   ☐Stress test ☐Holter monitor ☐Echocardiogram
   _____
6) Is your atrial fibrillation being or has been treated with medication? ☐No ☐Yes If yes; provide the name of medication, dosage and frequency and date last used:
   _____
7) Has your atrial fibrillation been treated with surgical procedure? ☐No ☐Yes If yes; please check what applies ☐Electric cardioversion ☐Chemical cardioversion ☐Catheter Ablation (Pulmonary vein isolation ablation) ☐Pacemaker ☐Implantable defibrillator
   Provide date(s) and results of any of the above check procedure(s)
   _____
8) When did you last see your cardiologist for evaluation and what were results?
   _____
9) Is there family history of heart disease or cancer? ☐No ☐Yes If yes; provide details including relationship to yourself, age of onset, type and current age or date of death
   _____
10) Do you exercise three or more times per week on a regular basis? ☐No ☐Yes If yes; provide details
    _____
11) Have you made any lifestyle changes to improve your overall health? ☐No ☐Yes If yes; provide details
    _____
    _____
12) Are you being treated for any other medical conditions? ☐No ☐Yes If yes; provide details
    _____
    _____
13) Please list all current medications, dosages and what condition the medication is treating
    _____
    _____
    _____

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Please use additional pages if needed

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