Stroke – TIA or CVA 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) What was date of stroke? _____ Were you hospitalized? ☐Yes ☐No If yes; provide details:_____
2) Was it diagnosed as TIA (Transient Ischemic Attack) or CVA (Cerebrovascular Accident)? ☐TIA ☐CVA
3) What follow up studies were done following the stroke (CVA) or mini stroke (TIA)? Please check all that apply: ☐CT Scan Date_____ ☐MRI Scan Date_____ ☐Carotid ultrasound/Doppler Date:_____ ☐Echocardiogram Date:_____☐Stress Test Date:_____ ☐Other_____ Date:_____
4) Was this the first (ONLY) occurrence? ☐Yes ☐No If not; when were prior instances?

   _____

   Was cause of the stroke determined? ☐Yes ☐No If yes; provide complete details

   _____

   _____
5) Is there any residual neurologic or cognitive impairments? ☐Yes ☐No If yes; provide complete details

   _____

   _____
6) Do you currently have or ever had any history of CAD (Coronary Artery Disease), PVD (Peripheral Vascular Disease), diabetes, hypertension or smoking? ☐Yes ☐No If yes; provide details **"yes" to a CT or MRI, carotid Doppler and street test are required for review for accurate assessment**

   _____

   _____
7) Have you been diagnosed with any of the following conditions? ☐Hypertension-Avg. BP: ____ /_____ ☐Peripheral vascular disease ☐Kidney/renal disease ☐Internal carotid artery stenosis ☐Left ventricular hypertrophy ☐Cardiomyopathy ☐Diabetes-Avg. A1c: ____ ☐ Atrial fibrillation ☐Coronary artery disease
8) Do you exercise three or more times per week on a regular basis? ☐Yes ☐No If yes; provide details

   _____
9) Have you made any lifestyle changes to improve your overall health? ☐Yes ☐No If yes; provide details

   _____
10) Are you being treated for any other medical conditions? If yes; provide details

    _____
11) Is there family history of heart disease or cancer? ☐Yes ☐No If yes; provide details including relationship to yourself, age of onset, type and current age or date of death

    _____
12) When did you last see your physician for evaluation and what were results?

    _____
13) Please list all current medications, dosages and what condition the medication is treating

    _____

Please use additional pages if needed

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