



INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

Arrhythmia Questionnaire

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.

Agent's Name: _____ Phone #: _____

Proposed Insured: _____ Date of Birth: ___/___/___

Male () Female () Height _____ Weight _____ Smoker () Non Smoker ()

Amount of Coverage \$ _____ Product Type _____

1. What type of arrhythmia? _____

2. What was the cause? _____

3. Date of the first attack? _____

4. Provide details what type of treatment was given? _____

5. Provide details of medication (i.e. type, dosage, frequency)? _____

6. Are there any associated conditions or other health problems? _____

7. Has any recent testing been done (i.e. EKG, Holter Monitor, etc.)? _____

8. Any symptoms such as syncope, dizziness, and/or palpitations? _____

9. Is there a family history of arrhythmia? _____

FAMILY HISTORY

Family Member	Age	If Living State of Health or Cause of Death	Age at Death
Father			
Mother			
Brother (s)			
Sister (s)			