

MITRAL VALVE PROLAPSE

CLIENT NAME: _____ **Date:** _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor **Type of Coverage:** Term UL Survivor UL

Coverage Amount: _____ **Anticipated Premium:** _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. How long has this abnormality been present? _____

2. Have any of the following symptoms occurred? (check all that apply)

- Fainting or dizziness No Yes
 Palpitations No Yes
 Shortness of breath No Yes
 Chest pain No Yes

3. Is there a history of any other heart disease in addition to the mitral valve prolapse (problems with other valves, coronary artery disease, etc.)?

No Yes; please submit a copy of the report

4. Has an echocardiogram (ultrasound of the heart) been done? No Yes; please submit a copy of the report

5. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Are there any other health problems? (additional questionnaires may be required) No Yes; please give details

FAMILY HISTORY (ADDENDUM)

CLIENT NAME: _____ Date: _____
 Male Female Date of birth: _____ Height: _____' _____" Weight: _____

1. Has the proposed insured had relative(s) with any of the following:

- Parent
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____
- Brother
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____
- Sister
 Has had: Cancer Diabetes Stroke Heart disease Committed suicide Other (explain below)
 Age of onset: _____ Date of death: _____

2. If yes to any of the above, please provide details/information
