Reliable Financial Group

A CPS Insurance Services, Inc. Affiliated Office
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Bypass Questionnaire

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. Your client may need to contact his/her physician to obtain needed information.

CLIENT: NAME _____ ☐ **M** ☐ **F DOB** _____ **AGE** _____ **HT** _____ **WT** _____ **STATE** _____

AMT. 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 _____ **DOES CLIENT WORK FULL TIME** ☐ **YES** ☐ **NO**

IF ANY DECEASED FAMILY, 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) _____/_____ **IS CLIENT TREATED FOR BLOOD PRESSURE** ☐ **NO** ☐ **YES**

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ **TREATED FOR CHOLESTEROL** ☐ **NO** ☐ **YES**

AGENT: NAME _____ **PHONE** _____**E- MAIL**_____

(1) Date(s) or frequency of episode(s) of symptoms relating to the bypass surgery (CABG):
(a) Angina pectoris: _____
(b) Coronary thrombosis/occlusion: _____
(c) Coronary insufficiency: _____
(d) Myocardial infraction (heart attack): _____

(2) Provide dates if any of the following tests or revascularization procedures that have been done?
❒ Resting EKG: _____ ❒Stress EKG: _____
❒ Thallium Stress EKG: _____ ❒Echocardiogram: _____
❒ Coronary Catheterization: _____ ❒Coronary Angioplasty: _____
❒ Percutaneous transluminal angioplasty (PTCA): _____ ❒Directional Coronary Atherectomy: _____
❒ Rotational Atherectomy: _____ ❒Coronary Artery Stents: _____
❒ Laser treatment: _____ ❒Perfusion Balloon Catheter: _____
❒ Other: _____

(3) Please check if the proposed insured as been diagnosed with the following conditions:
❒ Elevated Cholesterol - most recent known level(s): _____
❒ High blood pressure - most recent reading: _____/_____
❒ Diabetes - age of onset: _____ Recent A1C test result: _____ (also, please ask for our Diabetes Questionnaire)
❒ Family history of heart disease. If yes, who and at what age(s) diagnosed: _____
❒ Other: _____

(4) Does the proposed insured take any current medications, including preventative aspirin? No❒ Yes❒

Name of Medication	Dates Used	Quantity Taken	Frequency Taken

(5) Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)?
No❒ Yes ❒ Details: _____

(6) Does the proposed insured engage in any regular exercise or sporting activity?
No ❒ Yes❒ Details:
_____