Reliable Financial Group

A CPS Insurance Services, Inc. Affiliated Office
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Heart-Treatment Angioplasty

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) Provide date(s) or frequency of episode(s) of symptoms that have lead to the angioplasty:

(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 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 Stent(s) Number________________
- ❒ Laser treatment: ____________________________
- ❒ Perfusion Balloon Catheter: ___________________
- ❒ Bypass Surgery: ______________________________ Number of vessels involved: ______________________________
- ❒ Other: ____

(3) Please check if the proposed insured as been diagnosed with the following conditions:

- ❒ 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