MRW FINANCIAL BROKERAGE

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Coronary Underwriting Questionnaire

Agent Name_____ Phone _____

Email Address _____

Applicant Last Name _____ Date of Birth _____

Sex ☐ Male ☐ Female Height/Weight _____ / _____

Occupation _____ Ever use nicotine products? ☐ No ☐ Yes

If yes, select type: ☐ Cigarettes ☐ Cigar ☐ Chewing tobacco ☐ Other: _____

Date last used _____ Frequency per month _____

Product Applying for: ☐ Term ☐ Universal Face Amount _____

1. **List date (s) of diagnosis and type of coronary artery disease**: _____
2. **Does the client's family have any history of heart disease?** ☐ No ☐ Yes- If yes list family members, age of onset and or age of death
   _____
3. ☐ **Chest pain or Angina** Date symptoms began/frequency : _____
   ☐ **Heart attack(s) (MI)** Dates: _____
   ☐ **Bypass surgery(ies) (CABG)** Dates: _____ How many vessels? _____
   ☐ **Angioplasty(ies) (PTCA)*** Dates: _____ How many vessels? _____
   ☐ **Atherectomy(ies)*** Dates: _____ How many vessels? _____
   *If Stents were placed at the time of PTCA or Atherectomy: How many, per date? _____
   ☐ **Heart valve disease or surgery** Date of diagnosis: _____
   ☐ **Abnormal heart rhythm or pulse** Date of diagnosis: _____
   ☐ **Abnormal EKG (electrocardiogram)** Date of diagnosis: _____
   ☐ **Heart Murmur** Date of diagnosis: _____
   ☐ **Heart Failure** Date of diagnosis: _____
   ☐ **Atrial fibrillation or flutter:** Chronic (permanent) OR Paroxysmal (intermittent or fast heart beat)
   Cause: _____
   Treatment to get the heart back to the normal rhythm: _____
4. **Have any of the following test(s) been completed?**
   ☐ **Thallium stress ECG** Date: _____ Results: _____
   ☐ **Stress echocardiogram** Date: _____ Results: _____
   ☐ **Coronary Angiography** Date: _____ Results: _____
   ☐ **Echocardiogram** Date: _____ Results: _____
   ☐ **Chest X-ray** Date: _____ Results: _____
   ☐ **Others: _____** Date: _____ Results: _____
5. **Have you had any of the following? (If yes, please complete any/all appropriate questionnaires.)**
   ☐ Abnormal Lipid levels ☐ Irregular heartbeats ☐ Elevated homocysteine ☐ Cancer ☐ Diabetes ☐ Overweight
   ☐ High blood pressure ☐ Elevated cholesterol Overweight ☐ Peripheral Vascular Disease ☐ Cerebrovascular or carotid disease
6. **Do you exercise on a regular basis?** _____
7. **<u>BY-PASS OR STENTS</u>:**
   a. Number of vessels by-passed: _____ b. How badly were the vessels occluded? (percentage) _____
   c. Has a follow-up stress (exercise ECG been completed since the procedure?
   ☐ No ☐ Yes- Normal, Date: _____ ☐ Yes-Abnormal, Date: _____
   d. Has client had any chest discomfort since the procedure? ☐ No ☐ Yes
   Details: _____
8. **Please list all medications you are currently taking:**

Name of Medication	Dosage	Reason

Please fax this form to MRW Financial Inc. 813-875-7331 or email to marie@mrwfinancial.com