



**AORTIC VALUE DISORDER
PRELIMINARY UNDERWRITING QUESTIONNAIRE**

Client:

Gender: M F **DOB:**
Height: **Weight:**
Plan Desired?

Coverage Desired?

Amount?

If your client has Aortic Valve Disorder, please answer the following:

AORTIC VALUE DISORDER HISTORY

1. **How long has this abnormality been present?** (years)
2. **Which type(s) of Aortic Valve Disorder is/are present?** *Select all that apply.*
 Aortic Stenosis
 Aortic Sclerosis
 Aortic Insufficiency
3. **Have any of the following occurred?** *Select all that apply.*
 chest pain
 palpitations
 trouble breathing
 dizziness, fainting
 heart failure
4. **Is there a history of any other heart disease in addition to the Aortic Valve Disorder (problems with other valves, coronary artery disease, etc.)?** Yes No
If yes, please give details:
5. **Have additional studies been completed?** *If yes, please list study date.*
 echocardiogram (date)
 cardiac catheterization (date)
 none

CURRENT STATE

6. **Please list current medications:**
7. **Has your client smoked cigarettes in the last 12 months?** Yes No
8. **Does your client have any other major health problems (ex: cancer, diabetes, etc.)?** Yes No
If yes, please give details:

ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

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