ATRIAL FIBRILLATION

PRELIMINARY UNDERWRITING QUESTIONNAIRE

Client: **Gender:** M F **DOB:**

Height: **Weight:**

Coverage Desired? **Amount?** **Plan Desired?**

If your client has Atrial Fibrillation, please answer the following:

HEART HISTORY

1. **Please list date when first diagnosed:**
2. **Indicate whether the atrial fibrillation/flutter is:** Chronic Paroxysmal (intermittent)

   If intermittent, please specify how often is occurs:
3. **Are there any symptoms with the irregular heart beat?** Yes No

   If yes, please give details:
4. **Have any of the following tests been done?** *Select all that apply and provide details.*

   Stress Test (date) (results)
   Echocardiogram (date) (results)
   Holter monitor (date) (results)
5. **Have you had any of the following medical procedures?** *Select all that apply and note date of procedure.*

   Cardioversion (date)
   Catheter ablation (date)
   Surgeries (date)
6. **The cause of the fibrillation/flutter is due to:**

   Coronary heart disease — Alcohol
   Thyroid disease — Cardiomyopathy
   Valve disease — Hypertension
   Sick sinus syndrome — Unknown or other

CURRENT STATE

7. **Does your client take any medications or have a pacemaker?** Yes No

   If yes, please give details:
8. **Has your client smoked cigarettes in the last 12 months?** Yes No
9. **Does your client have any other major health problems (*ex: heart disease, etc.*)?** Yes No

   If yes, please give details:

ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

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Version 7/16