

RACCUGLIA FINANCIAL BROKERAGE, INC.

"Commitment to Integrity and Service"

Quick Quoter
Clinical Underwriting®

Heart Disease

Date: ___/___/___

Agent Name	Fax	
Address	Phone	
City	State	Zip

Client's Name: _____ Date of Birth: ___/___/___

Sex: Male Female Height: _____ Weight: _____ lbs.

Smoker: No Yes (If yes, also complete Tobacco Questionnaire)

Insurance Amount: _____ Insurance Type: Term UL Survivor UL

Additional Insured's Name (only if applying for Survivor UL): _____

OTHER COMPANY ACTIONS: Company: _____ Date applied: ___/___/___

Declined Postponed Rated Table: _____

1. Which of the following procedures has the client undergone?

CORONARY BYPASS Age _____ Date ___/___/___

ANGIOPLASTY (go to #4) Age _____ Date ___/___/___

2. How many grafts were performed? 1 2 or 3 4 or more

3. What type of grafts were performed? Saphenous Vein Internal Mammary Artery Both

4. Where was coronary angioplasty performed? Single artery More than one artery

5. Select all conditions that preceded the coronary bypass/angioplasty Heart attack Chest pain

Irregular stress EKG Extreme fatigue Other _____

6. Since the coronary bypass/angioplasty, which of these has client experienced?

Chest pain Irregular stress EKG Neither

7. List names and addresses of the physicians and hospitals with client's complete medical records _____

8. Timing and results of last stress EKG Past 12 months 1-2 years 3 years or more

Results: _____

Note: Please complete questions #9 thru #14 on page 2 of this form before submitting

Quick Quoter
Clinical Underwriting®

Heart Disease

Date: ___/___/___

Agent Name	Fax
Address	Phone
City	State Zip

Client's Name: _____ Date of Birth: ___/___/___

9. Date and result of last cholesterol reading ___/___ Reading: _____

10. Date and result of last blood pressure reading. ___/___ Reading: _____

11. Has either parent, or any sibling, died before age 65, other than by accident? No Yes

List relationship(s): _____ Cause(s): _____

12. How many times per week does client exercise?

None 1 2 3 4 5 6 7 More than 7

Type of exercise: _____

13. Are there any other illnesses/impairments? _____

14. What medications are currently being taken? _____

ADDITIONAL INFORMATION: _____
