BROOKFIELD PARTNERS

Cardiac / Atrial Fibrillation Questionnaire

UNDERWRITING QUESTIONNAIRE

AGENT & CASE INFORMATION

AGENT NAME | PHONE | E-MAIL

PROPOSED INSURED

CLIENT NAME | DATE OF BIRTH | STATE

HEIGHT | WEIGHT | FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. When was the proposed insured diagnosed with Atrial Fibrillation?

2. Has the proposed insured been diagnosed with:

☐ Chronic Atrial Fibrillation ☐ Paroxysmal Atrial Fibrillation

3. What is the underlying cause of the Atrial Fibrillation? (Check all that apply)

☐ High blood pressure ☐ Coronary artery disease ☐ Cardiomyopathy

☐ Heart valve disease ☐ Having undergone heart surgery ☐ Chronic lung disease

☐ Heart failure ☐ Congenital heart disease ☐ Pulmonary embolism

☐ Hyperthyroidism ☐ Pericarditis ☐ Viral infection

☐ Other

4. Has the proposed insured had any of the following symptoms?

☐ Chest discomfort Date:

☐ currently experiences

☐ Black-out Date:

☐ currently experiences

- ☐ Palpitations Date: _____
- ☐ currently experiences
- ☐ Dizziness/faint feeling Date: _____
- ☐ currently experiences

5. Has the proposed insured ever had any of the following procedures?

- ☐ Electrical Cardioversion Date: _____
- ☐ Ablation Date: _____
- ☐ Pulmonary vein antrum isolation Date: _____
- ☐ Implantation of a defibrillator or pacemaker Date: _____

6. Is the proposed insured taking any medication(s)? ☐ Yes ☐ No

If yes, provide name, dosage and frequency of medication(s):

_____