BROOKFIELD PARTNERS

Cardiomyopathy 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?

2. The condition was diagnosed as:

- ☐ Dilated Cardiomyopathy
- ☐ Hypertrophic Cardiomyopathy
- ☐ Restrictive Cardiomyopathy
- ☐ Other

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

- ☐ Chest pain or pressure ☐ Shortness of breath ☐ Fatigue
- ☐ Swelling of lower extremities ☐ Weight gain ☐ Fainting
- ☐ Palpitations ☐ Dizziness

4. Has the proposed insured Undergone any of the following procedures?

- ☐ Pacemaker Date:
- ☐ Implantable cardioverter defibrillator Date:

☐ Other: Date:

5. Is there a family history of heart disease? ☐ Yes ☐ No

If yes, provide relationship to proposed insured and date of onset and/or death:

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

If yes, provide name, dosage and frequency: