AORTIC VALVE DISORDER

Agent Name:_____ Phone:_____
Email Address:_____ State:_____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Tobacco Sex: M/ F:_____

Usage: _____ Face Amount: _____

☐ Term 10 15 20 30 ☐ UL

1. Date of diagnosis: _____

2. Have you been diagnosed or have you experienced any of the following:

☐ Light headedness ☐ Breathlessness ☐ Blackouts
☐ Aortic stenosis ☐ Coughing up blood ☐ Rheumatoid arthritis
☐ Syphilis ☐ Ankylosig spondylitis ☐ Marfan's syndrome
☐ Edema
☐ Elevated Cholesterol - most recent known levels: Date: _____
LDL _____ HDL _____ Triglycerides _____
☐ High blood pressure - most recent reading(s): _____
☐ Diabetes - age of onset: _____ Recent A1C test result: _____
(Also, please ask us for our Diabetes Questionnaire)
☐ Family history of heart disease (If yes, who and at what age(s) diagnosed): _____
☐ Other: _____

3. Provide dates if any of the following tests or procedures (a) have been done or (b) have been recommended to be done?

☐ Resting EKG: _____ ☐ Stress EKG: _____
☐ Thallium Stress EKG: _____ ☐ Echocardiogram: _____
☐ Coronary Catheterization: _____ ☐ Stress Echocardiogram: _____
☐ Valve replacement surgery - which valves? _____
☐ Angioplasty - what specific type? (e.g. balloon...) _____
☐ Bypass Surgery: _____ Number of vessels involved: _____
☐ Other: _____

4. Does the proposed insured take any current medications, including aspirin? ☐ Yes ☐ No
(If yes please provide name, dosage, and frequency):

5. Does the proposed insured follow a specific diet (e.g. vegetarian) or take dietary supplements (vitamins, folic acid, etc.)? ☐ Yes ☐ No (If yes, please provide details):

6. Does the proposed insured engage in any regular exercise or sporting activity? ___Yes ___No
(If yes, please provide details):

7. Are there any other conditions that may impact life underwriting? ☐ Yes ☐ No
(If yes, please provide details):

Please fax to 612-392-7644 or email to mvp@mvpservicesolutions.com