Pacemaker Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date of first Diagnosis		When was the last checkup?
2	Does client have another heart disease	☐ Yes ☐ No	*If yes, give details,*
3	The pacemaker was implanted for	☐ Heart block associated with coronary artery disease	
		☐ Complete heart block or sick sinus syndrome	
		☐ Chronic underlying atrial flutter/fibrillation	
		☐ Other	Details:
4	Aer there any continuing symptoms since the pacemaker was implanted?	☐ Yes ☐ No	*If yes, give details*
5	List current medications (accurate name, dosage and reason)		
6	Does the client have any other health issues	☐ Yes ☐ No	*If yes provide details:*