

NT-proBNP QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
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Proposed Insured Name: _____		<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: _____	
Face Amount: _____	Max. Premium: \$ _____/year	<input type="checkbox"/> UL	<input type="checkbox"/> WL	<input type="checkbox"/> Term	<input type="checkbox"/> Survivorship
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N		If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____			
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N					
If Yes, please provide details: _____					
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____					

(1) Is there a history of NT-proBNP testing? Y N

If so, most recent reading: _____

(2) Is there a history of coronary artery disease? If so, details: _____

(3) Is the proposed insured taking any medications? If yes:

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

(4) Have you had any diagnostic cardiac testing performed? Y N

If so, please provide details including date, type of testing, and results: _____

(5) Do you have any of the following cardiac risk factors?

- Hypertension Hyperlipidemia Tobacco Diabetes Family history in father, mother or siblings

(6) Do you have any cardiovascular history (coronary artery disease, cerebral vascular disease, atrial fibrillation/arrhythmia, COPD, etc.)? Y N

If yes, please provide details (including when diagnosed and treatment): _____

(9) Does the proposed insured have any other medical conditions that may affect underwriting? If yes, please provide details:
