



Field Underwriting Questionnaire - Stroke

Name: _____

Male Female DOB _____

Height _____ Weight _____

Smoker? Yes No

Insurance Amount _____

Insurance Type UL/WL Term

1. When did you have your first stroke?
month/year _____

2. When did you have your first stroke?
month/year _____

3. Number of strokes in last 24 months?
 none
 one
 two or more

4. Have you ever had a carotid artery surgery as a result of a stroke?
 Yes No
 If yes, month/year _____

5. Do you have any of the following residual neurological deficits?
 slurred speech
 loss of use of limb
 restricted use of limb
 any other impairment

6. Approximate date of last stress EKG?
 within the last 12 months
 one to two years
 two plus years

7. Please list last cholesterol reading (if known) _____

8. Please list last blood pressure reading (if known) _____

9. Do you regularly exercise 3 or more times per week?
 Yes No
 If yes, type _____

10. Please list any other illness or impairment.

11. Please list any medications currently being taken.

12. Has either parent, or any siblings died before age 65, other than by accident?
 Yes No
 If yes, cause: _____

13. Please list the time life insurance was applied for and the result.

Company _____

Date applied _____

Action taken:

Declined
 Postponed
 Rated table _____

COMMENTS: _____

Agent _____

Phone _____

Fax _____