

Angina Quote Request

Name _____ Sex M F Date of Birth _____

Height _____ Weight _____ Smoker? Y N State _____

Coverage Desired? _____ Amount _____ Plan Desired? _____

Have you ever been Rated or Declined for insurance? If YES Complete details please

When did you first experience symptoms of Angina or Chest Pain? _____

Was it associated with exercise, exertion, excitement, any other circumstance? _____

If more than one attack, give frequency, duration, and date of last attack _____

Has treatment been completed? If YES, When? _____

Have you had any of the following tests?

Please check all that apply

Resting EKG _____

Stress Echocardiogram _____

Thallium Stress EKG _____

Ultrafast CT _____

Angiography _____

Stress EKG _____

Muga Scan _____

Do you have any of the following:

Please check all that apply

High Blood Pressure _____

Family History of Heart Disease _____

Abnormal Lipid Levels _____

Elevated Homocysteine _____

Do you have Diabetes? Y N When Diagnosed? _____

If YES, what medication are you taking? _____

What have been your recent Blood Pressure readings? _____

What has been your recent Cholesterol readings? _____

Have you had any of the following?

Please check all that apply

Heart Attacks(s) Please give dates _____

Bypass Surgery(s) Please give dates and number of vessels _____

Angioplasty(s)) Please give dates and number of vessels _____

Please list all medications being taken: _____

Do you have any other major health problems? (example: cancer, etc)? _____

Please also submit a copy of any recent Angiograms or Stress Tests

Broker Submitting Questionnaire: _____

Address _____

Phone: _____ FAX: _____ E-mail: _____

Please send completed form:

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