Atrial and Venticular Septal Defects

Please answer all questions applicable to the client's medical history.

Producer Name_____ Phone _____ Date_____

Client Name_____ Date of Birth_____ ☐ Male ☐ Female

Face Amount _____ Max Premium $_____ /yr. ☐ Term ☐ Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? ☐ Yes ☐ No

Frequency_____ Date of last use _____ Type _____

Date of diagnosis_____

Check type of septal defect

- ☐ ASD, ostium secundum or sinus venosus
- ☐ ASD, primum
- ☐ VSD, large
- ☐ VSD, small
- ☐ VSD, moderate

Has surgical repair(s) been completed? If yes, provide details below

_____

Are any other congenital defects present? Provide details

_____

Check if any of the following have occured before or after surgery and provide details

- ☐ Heart enlargement_____
- ☐ Pulmonary hypertension _____
- ☐ Bundle branch block on ECG_____
- ☐ Arrhythmia_____
- ☐ Symptoms_____
- ☐ Blood clots_____
- ☐ Stroke_____
- ☐ Heart valve disease_____

Is the client on any medications? If yes, provide details

_____

Date of recent echocardiogram_____

Results_____

List any other major health problems the client has:

Questions?

Please call your McGill Brokerage Marketing Team at 800-279-0751.