



Cardiomyopathy

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 _____

This condition has been diagnosed as

- | | |
|--|---|
| <input type="checkbox"/> Dilated cardiomyopathy | <input type="checkbox"/> Hypertrophic cardiomyopathy |
| <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Idiopathic hypertrophic subaortic stenosis |
| <input type="checkbox"/> Myocardial fibrosis | <input type="checkbox"/> Alcoholic cardiomyopathy |
| <input type="checkbox"/> Myocardial degeneration | <input type="checkbox"/> Peripartum cardiomyopathy |
| <input type="checkbox"/> Congestive cardiomyopathy | <input type="checkbox"/> Restrictive cardiomyopathy |
| <input type="checkbox"/> Other _____ | |

Provide dates if any of the following tests or procedures have been done to evaluate the condition

- | | |
|--|---|
| <input type="checkbox"/> Resting EKG _____ | <input type="checkbox"/> Stress EKG _____ |
| <input type="checkbox"/> Thallium stress EKG _____ | <input type="checkbox"/> Echocardiogram _____ |
| <input type="checkbox"/> Holter monitor _____ | <input type="checkbox"/> Chest X-ray _____ |
| <input type="checkbox"/> Other _____ | |

Family history of heart disease or premature death due to heart disease

Relation	Age (if living)	Age at Death	Cause of Death

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has:

Questions?

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