

Life Scan Questionnaire for **CORONARY BYPASS OR ANGIOPLASTY**  
 LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For \_\_\_\_\_  Male  Female  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  Non Smoker  Smoker  
 Have you ever used tobacco?  Yes  No If Yes, state month  
 and year of last use of any tobacco product: \_\_\_\_\_  
 Type of tobacco used  Cigarettes  Cigars  Chews  Pipe  
 Amt \$ \_\_\_\_\_ Type  Whole Life, Variable or Universal  Term  
 Last application for life insurance: Year \_\_\_\_\_ Company \_\_\_\_\_  
 Result :  Preferred  Standard  Rated/Rating \_\_\_\_\_  Declined  
 Life Insurance Risk Evaluation and Market Search for Best Offer  
 Risk Evaluation Only

Which of the following procedures was completed?

- Coronary Bypass  
 Coronary Angioplasty (start at # symbol)

List Month and Year of Coronary Bypass or Angioplasty

Month \_\_\_\_\_ Year \_\_\_\_\_

Coronary Bypass, If a second bypass was performed, please indicate

Month \_\_\_\_\_ Year \_\_\_\_\_

How many grafts were performed?

- 1  2  3  4  5  6 or more

Indicate type of grafts used?

- Shaphenous vein (from legs)  Internal mammary artery  Both

# Coronary Angioplasty, indicate when performed.

Month \_\_\_\_\_ Year \_\_\_\_\_ With stent?  Yes  No

If second angioplasty was performed, indicate when

Month \_\_\_\_\_ Year \_\_\_\_\_ With stent?  Yes  No

The procedure was performed on how many arteries?

- 1  2  3  4  5  6 or more

What condition preceded the Coronary Bypass or the Coronary Angioplasty?

Check all that apply

- Heart attack  Chest pain  Extreme fatigue  
 Irregular stress EKG  Other \_\_\_\_\_

Since the Coronary Bypass or Coronary Angioplasty, have you experienced any of the following:

- Chest pain  Irregular stress EKG  
 No problems since the surgery  Other \_\_\_\_\_

Date last seen by a physician or medical practitioner?

Month \_\_\_\_\_ Year \_\_\_\_\_ Reason \_\_\_\_\_

Life Factors

**Date of last stress EKG**

Month \_\_\_\_ Year \_\_\_\_  Never

**Family History**, has either parent or any sibling died before age 65?

Yes  No If yes, please list cause and age.

**Blood Pressure**, with or without medication \_\_\_\_\_ / \_\_\_\_\_

List medication, if any

**Cholesterol** \_\_\_\_\_

List all **other illnesses** not listed on this page.

List all medications currently being used.  
 (name, dosage and times per day)

Agent Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

ST \_\_\_\_ Zip \_\_\_\_ email \_\_\_\_\_

Phone \_\_\_\_\_



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This is not an application for life insurance. The information contained herein will be used solely for the purpose of assessing which insurance carriers are likely to respond most favorably to the risk situation as stated above. The questions and answers listed will be used in the evaluation of the person listed above. All quotes are tentative, and are subject to the submitted medical evidence and other criteria used in the underwriting of life insurance.

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