Risk Assessment– Valve Replacement

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	**Male** **Female**
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	**Term** **UL** **Whole Life** **2nd To Die**
Has Client EVER Used Tobacco? **YES** **NO**	**Date of Last Use:**
Specify All Types of Nicotine Used:	**Cigarettes** **Cigar** **Pipe** **Other:**
What Valves Were Replaced?	**Date & Details:**
Date when last saw Doctor:	
How often does client see Doctor:	

Is Client on Any Medications?	**List All RX:**
Date of last Echocardiogram:	
Any other medical problems Or hospitalizations?	**List Here (and complete appropriate questionnaire for each condition):**

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment:___________________________

____