MADISON™ BROKERAGE
The Advisor's Advisor
ACRISURE® PARTNER

ATRIAL FIBRILLATION QUESTIONNAIRE

Agent: _____ **Phone:** _____ **Fax:** _____

Proposed Insured Name: _____ (M or F): _____ Age: _____

Face Amount: _____ Max Premium $: _____ / year Type: (UL, WL, Term, or Survivorship) _____

Do you currently smoke cigarettes? (Y or N): _____ If no, did you ever smoke: (Y or N): _____ Quit date: _____

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum…):

If Yes, please provide details: _____

When did you last use any form of tobacco: (Month) _____ (Year) _____ Type used last: _____

Date of Diagnosis: _____ Is the atrial fibrillation/flutter: Chronic (permanent) OR Paroxysmal (intermittent) _____

Are there any symptoms with the irregular heart beat? (Y or N):

- Black-out _____
- Dizzyness (light-headedness/faint feeling) _____
- Palpitations _____
- Chest discomfort _____
- Other: _____

Have any of the following tests been performed? If so, please give date and results:

- ECG _____
- Stress Test _____
- Echocardiogram _____
- Holter Monitor _____

Is your client on any medications?

Name of Medication:	Dates Used:	Quantity Taken:	Frequency Taken:

The cause of the atrial fibrillation/flutter is due to: (Y or N)

- Coronary Heart Disease _____
- Alcohol _____
- Thyroid Disease _____
- Mitral Valve Disease _____
- Cardiomyopathy _____
- Other _____

Does your client have any other major health problems (ex: stroke, etc.)? (If Yes, please explain)

_____

_____

_____