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## Questionnaire For: Arrhythmia

Information gathered will be used in the evaluation of the insurability of the applicant. Offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

Agent's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Proposed Insured: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
 Male ( ) Female ( ) Height \_\_\_\_\_ Weight \_\_\_\_\_ Smoker ( ) Non Smoker ( )  
 Amount of Coverage \$ \_\_\_\_\_ Product Type \_\_\_\_\_

1. What type of arrhythmia?
2. What was the cause?
3. Date of the first attack?
4. Provide details what type of treatment was given?
5. Provide details of medication (i.e. type, dosage, frequency)?
6. Are there any associated conditions or other health problems?
7. Has any recent testing been done (i.e. EKG, Holter Monitor, etc.)?
8. Any symptoms such as syncope, dizziness, and/or palpitations?
9. Is there a family history of arrhythmia?

### FAMILY HISTORY

Family Member	Age If Living	State of Health or Cause of Death	Age at Death
Father			
Mother			
Siblings			