



(To be completed by the Applicant)

Name _____ Date of Birth _____ No. _____
(Mo. Day Yr.)

1. Have you ever had: chest pain? _____ palpitation? _____ skipping of heart? _____ shortness of breath? _____

2. Did it involve: a sense of pressure or constriction? _____ a burning sensation? _____ sharp pain? _____
aching? _____ sweating? _____

3. Date of onset, duration, severity, location. Was it associated with exertion, exercise, excitement or other circumstances?

Give details _____

If more than one attack, give frequency, duration, and date of last attack _____

4. What diagnosis was made concerning your symptoms: myocardial infarction? _____ coronary occlusion? _____
coronary insufficiency? _____ angina pectoris? _____ other? _____

5. Were you: given emergency medical care? _____ hospitalized? _____

6. Date of return to work: _____ Any restrictions on activities? _____

7. What medicines are you taking now? _____

8. Names and addresses of all physicians consulted since onset of chest pain: _____

I hereby declare that the above statements are complete and true to the best of my knowledge and belief, and I agree that they shall form part of my application for insurance.

Signature of
Proposed Insured _____ Witness _____

Date _____