

MEDICAL HISTORY QUESTIONNAIRE: PACEMAKER

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

Never

Former Date Stopped: _____

Current Type: _____

Coverage Information:

Type: Term UL IUL

WL VUL Survivorship

Face Amount: _____

Premium Tolerance: _____

PROPOSED INSURED'S EXISTING INSURANCE

INSURANCE COMPANY	FACE AMOUNT	YEAR ISSUED	REPLACEMENT (YES/NO)

1. Date the pacemaker was implanted: _____

2. The pacemaker was implanted for:

Heart block associated with CAD

Complete heart block or sick sinus syndrome

Chronic underlying atrial fibrillation/flutter

Other, give details: _____

3. Does client have another heart disease? No Yes If Yes, please provide details: _____



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4. Have any of the following pacemaker complications occurred?

- Infection Blood Clots Pacemaker Malfunction
 Perforation Other, give details: _____

5. Are there any continuing symptoms since the pacemaker was installed? No Yes

If yes, please provide details: _____

6. When was the client's last checkup? _____

7. Please list current medications:

NAME OF MEDICATION	DOSAGE	REASON

8. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____



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