STAMM UNDERWRITING SUPPORT

Underwriting Support

Stroke (CVA)/Mini Stroke (TIA)

Please answer each question completely and provide as much detail as possible.

Producer Name: ___________________________________ Phone: __________________ Date _________

Client Name: ___________________________________ Date of Birth: __________________ Gender: _________

Coverage Type: ☐ Whole Life ☐ Term ☐ Universal Life Face Amount: __________________ Max Premium: _________

Please provide details of specific policy design requests, benefit riders, etc.: ____

____

____

Does the client current currently smoke cigarettes?

☐ Yes ☐ No

Does the client currently use any other form of tobacco products (i.e. nicotine patch, snuff, pipe, cigars, chew, Nicorette gum, etc.?)

☐ Yes ☐ No

If yes, please provide details: ____-

____

____

STROKE / MINI STROKE HISTORY

Please indicate whether the client suffered from a stroke (CVA) or mini stroke (TIA)

☐ Stroke ☐ Mini stroke Date: ____

What type of follow-up studies were done following the stroke or mini stroke? Check all that apply

☐ MRI Scan ☐ Echocardiogram ☐ CT Scan ☐ Cartoid Ultrasound ☐Other

If other, provide details: ____

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Was this is a single stroke (CVA) or have there been multiple episodes?

☐ Single stroke — If there has been more than one incident, provide dates and details: ____________________

____

Was this is a single mini stroke (TIA) or have there been multiple episodes?

☐ Single mini stroke — If there has been more than one incident, provide dates and details: ____________________

____

Please list and provide details of any residual neurological effects since the stroke or mini stroke: ____________________

____

____

Has there been an impact on the client's ability to perform daily living activities by themselves? Please provide details of any/all daily living activities that have been impacted: ____________________:

____

____

Has the client been diagnosed with any of these health conditions? Please check all that apply and provide date of diagnosis and type of treatment they are receiving.

☐ HYPERTENSION
Controlled?
Diagnosis date:

☐ DIABETES
Type:
Diagnosis date:
Recent A1C:

☐ HEART ATTACK
Date(s):

☐ CORONARY ARTERY DISEASE
Date of diagnosis:

☐ PERIPHEAL VASCULAR DISEASE
Date of diagnosis:
Treatment:

☐ CARDIOMYOPATHY
Date of diagnosis:

☐ VALVE DISORDERS
Details:
Date of diagnosis:

☐ ATRIAL FIB
Date of diagnosis:

In the space below, list any/all other health conditions and prior medical history issues with details and details: