AGENTS INSURANCE SERVICES of AMERICA, Inc.
Email: to UndSolutions@cs.com or Fax to: (760) 435 9703
Telephone: (760) 435 9702

Stroke, Cerebral Vascular Accident (CVA) or Transient Ischemic Attack (TIA) Questionnaire

Name [] Male [] Female Age Date of Birth

Tobacco Use [] No [] Cigarettes [] Other tobacco Date quit?

State Amount of Insurance Type of Insurance

Occupation/Source of income:

[] Stroke or Cerebral Vascular Accident (CVA), [] Transient Ischemic Attack (TIA)

1. Date (s) of Stroke (s):

- Dou you have any physical or neurological residuals: [] No [] Yes- Details:

2. Date (s) of TIA (s):

- Dou you have any physical or neurological residuals: [] No [] Yes- Details:

3. List all medications (including aspirin):

4. Test Results: [] Resting EKG – [] Normal [] Abnormal, [] Stress EKG [] Normal [] Abnormal, [] Echocardiogram [] Normal [] Abnormal, [] Carotid Ultrasound [] Normal [] Abnormal, [] Head CT scan and MRI [] Normal [] Abnormal.

5. Do you have any of the following complications: [] coronary artery disease, [] cardiac arrhythmia or irregular heart beat, [] CHF or congestive heart failure, [] heart murmur, [] diabetes, [] kidney disease, [] hypertension, [] peripheral vascular disease (PVD), [] family history of coronary disease or strokes?

Details #5:

6. How often do you visit your physician?

General Questions:
1. Do you have any other major health problems? [] No [] Yes – Details:

2. List all medications:

3. Height: Weight: Most recent blood pressure reading:

Agent Name:

Address: **City:** **State:** **Zip:**

Phone: **Fax:** **Email:**

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance