AMERICAN INCOME LIFE INSURANCE COMPANY
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HEART / CIRCULATORY QUESTIONNAIRE

INSURED'S NAME _____ APPLICATION NUMBER _____

CHEST PAIN

1. HAVE YOU EVER HAD:
   A. CHEST PAIN? ☐ YES ☐ NO
   B. SHORTNESS OF BREATH? ☐ YES ☐ NO
2. DATE OF OCCURENCE(S) _____
3. WHEN DID THE PAIN OCCUR (AT REST OR AFTER EXERCISE)? _____
4. DID YOU CONSULT A PHYSICIAN OR WERE YOU HOSPITALIZED? ☐ YES ☐ NO
   IF YES, WHAT IS THE NAME AND ADDRESS OF THE PHYSICIAN? _____
   WHAT IS THE NAME AND ADDRESS OF THE HOSPITAL? _____
5. WHAT WAS THE PHYSICIANS DIAGNOSIS? _____

HEART ATTACK QUESTIONNAIRE

1. HAVE YOU EVER BEEN DIAGNOSED WITH A HEART ATTACK? ☐ YES ☐ NO
   IF YES, PLEASE FURNISH NAME AND ADDRESS OF THE ATTENDING PHYSICIAN. _____
   WHAT IS THE NAME AND ADDRESS OF THE HOSPITAL WHERE CONFINED? _____
   HAVE YOU HAD MORE THAN ONE HEART ATTACK? ☐ YES ☐ NO
2. DATE OF HEART ATTACK(S) _____
3. HAVE YOU HAD ANGINA SINCE YOUR HEART ATTACK? ☐ YES ☐ NO
   IF YES, HOW OFTEN DO YOU HAVE ANGINA? _____
4. DO YOU CURRENTLY TAKE MEDICATION FOR YOUR HEART? ☐ YES ☐ NO
   IF YES, LIST ALL MEDICATION. _____
5. WHAT IS THE NAME AND ADDRESS OF THE PHYSICIAN WHO CAN FURNISH RECORDS OF CONSULTATION AND TREATMENT SINCE THE DATE OF YOUR HEART ATTACK? _____
6. WHEN DID YOU RETURN TO FULL TIME EMPLOYMENT? _____
   (MO/ DAY/ YR)