

Mutual of Detroit

Applicant Hypertension Questionnaire

Proposed Insured: _____ Policy Number: _____ Date of Birth: _____

REMARKS

YES NO

1) Are you currently under treatment for hypertension?

2) When were you first diagnosed with HTN?

3) Do you take your blood pressure readings yourself?

Three most recent BP readings (regardless of source):

| Source | Date | Reading |
|--------|------|---------|
| | | |
| | | |
| | | |

4) Are you currently taking medication for your HTN?
Please identify type and dosage.

Do you ever skip any dosages?

5) Name and address of medical practitioner treating you for HTN.

Date last seen and result:

6) Have you ever been treated for or diagnosed as having:

| | | | |
|---------------------------|--------------------------|--------------------------|---|
| a. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <i>If "Yes," indicate <input type="checkbox"/> Insulin <input type="checkbox"/> Non-Insulin dependent</i> |
| b. Coronary Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Stroke | <input type="checkbox"/> | <input type="checkbox"/> | |
| e. Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | |

7) Do you currently smoke?
*If "No," have you ever smoked? *If "yes," when did you quit?**

I represent that I have read and understand all the statements and answers in this questionnaire and that they are true and complete to the best of my knowledge. I agree that the statements and answers given in this questionnaire will be the basis of any insurance issued.

| | | |
|------------------|-------|------|
| Proposed Insured | Agent | Date |
|------------------|-------|------|