

AMERICAN INCOME LIFE INSURANCE COMPANY

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www.aillife.com

HIGH BLOOD PRESSURE QUESTIONNAIRE

INSURED'S NAME _____ APPLICATION NUMBER _____

DATE DIAGNOSED? _____

DO YOU TAKE MEDICATION? _____

IF YES, NAMES:

_____ DOSAGE _____ FREQUENCY _____

NAME AND ADDRESS OF DOCTOR WITH CURRENT RECORDS OF BLOOD PRESSURE: _____

DATE OF LAST VISIT: _____ READING: _____

IS BLOOD PRESSURE UNDER CONTROL? _____

HAVE YOU EVER BEEN HOSPITALIZED DUE TO YOUR BLOOD PRESSURE? (IF YES PLEASE PROVIDE THE DATE(S) AND DETAILS.): _____

ADDITIONAL REMARKS: _____

X _____ DATE _____
Proposed Insured's Signature

X _____
(Agent's Signature)

