

## MULTIPLE SCLEROSIS QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_/year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

(1) *Date of first diagnosis:* \_\_\_\_\_

(2) *How was the condition diagnosed?*  MRI  Evoked Potentials  Other: \_\_\_\_\_

(3) *Please complete the following table as much as possible:*

Approximate Date of Attack(s)	Duration of the Attack(s)	Residual Effects	Specify Impairment for Residual Effects
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	

(4) *Is there is disability, please provide the score for the Expanded Disability Status Scale (EDSS) or otherwise describe the disability:*

EDSS Score: \_\_\_\_\_ (0 through 10) *or* Description: \_\_\_\_\_

(5) *Does the proposed insured take any medications?*  No  Yes (please list below)

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(6) *Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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