PARKINSON'S DISEASE 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? ☐ Yes ☐ No If no, did you ever smoke? ☐ Never ☐ Quit (Date): _____
Do you currentl use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...)? ☐ Yes ☐ No
If yes, please provide details: _____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

1. Date of first diagnosis: _____

2. Describe current symptoms: _____

_____

3. Does the proposed insured take any medications or have been taken in the past? ☐ No ☐ Yes; please list below

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

4. Has any surgery been done? ☐ No ☐ Yes; please describe: _____

_____

5. Is the proposed insured independent (could live alone, without assistance)? ☐ Yes ☐ No; list extent of the disability:

_____

6. Is the proposed insured receiveing disability payments due to inability to work full time? ☐ No ☐ Yes; since (date): _____

7. Is the proposed insured participating in any kind of experimental treatment program? ☐ No ☐ Yes; please describe: _____

_____

8. Are there any other medical conditions or factors thay may be relevant to assessment of the insurability of the individual? If yes:

_____

_____

_____

_____

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