MADISON™ BROKERAGE
The Advisor's Advisor
ACRISURE® PARTNER

MULTIPLE SCLEROSIS QUESTIONNAIRE

Agent: _____ **Phone:** _____ **Fax:** _____

Proposed Insured Name: _____ (M or F): _____ Age: _____

Face Amount: _____ Max Premium $: _____ / year Type: (UL, WL, Term, or Survivorship) _____

Do you currently smoke cigarettes? (Y or N): _____ If no, did you ever smoke: (Y or N): _____ Quit date: _____

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

If Yes, please provide details: _____

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

Date of first diagnosis: _____ number of episodes: _____ date of last episode: _____

Current neurologic status and/or symptoms: Y or leave blank...

Normal _____

Minimal residual impairmet (please specify) _____

Moderate residual impairmet (please specify _____

Severe residual impairmet (please specify) _____

Does the proposed insured take any medications or have been taken in the past?

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

Please provide all MRI brain scan reports _____

Does your client have any other major health problems (ex: stoke, etc.) _____