PARKINSONISM/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? ❒ 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) Describe current symptoms: _____

_____

(3) Does the proposed insured take any medications or have any been taken in the past? ❒ No ❒ Yes; please list in table:

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 receiving 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 that may be relevant to assessment of the insurability of the individual? If yes:

_____

_____

_____

_____

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