Return to - jim@uswolfe.com or Fax to 815-377-3556

ARTHRITIS QUESTIONNAIRE

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. When were you first diagnosed with arthritis?

2. What type of arthritis do you have?
   Details:

3. Do you have to use any devices to assist you due to your arthritis? Yes No
   Details:

4. Are you able to take care of yourself? Yes No
   Details:

5. Are you able to work? Yes No
   Details:

6. Have you had any type of surgery due to arthritis? Yes No
   Date(s):
   Details:

7. Are you on any medication(s)? Yes No
   Name(s) and dosage(s):

8. Name, address & phone number of your physician(s) and the date last consulted:

Additional Information (please use reverse side for additional space):

Date: ________________ Insured's Signature: ______________________________