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

GASTROINTESTINAL 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. Date you first experienced symptoms:

2. What is your actual diagnosis?

3. Date of your last attack?

4. How often do you have attacks?

5. Are the attacks becoming more frequent? Yes No
   Details:

6. Do you experience any of the following?
   Black stool Vomiting Bleeding Relieved by eating

7. Have you had any weight loss in the past 6 months? Yes No
   Details:

8. Have you had any surgery(ies) for this disease? Yes No
   Details & Dates:

9. How often do you have a full work-up for your gastrointestinal problem?

10. What tests or procedures does the complete work-up include?

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

12. 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: _____