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

IMMUNODEFICIENCY 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. What is your actual diagnosis?

2. When were you diagnosed?
3. What were your first symptoms?

4. Please indicate dates and tests that have been completed to give you this diagnosis?
   Date: Test:
   Results:
   Date: Test:
   Results:
   Date: Test:
   Results:
   Date: Test:
   Results:

5. Have you ever had any blood transfusions? No Yes Date:
   Details:

6. Have you ever tested positive for HIV? No Yes Date:

7. What symptoms did you have that caused you to be tested?

8. Have you ever been told you have or had a STD, AIDS or AIDS related condition(s)? No Yes
   Details:

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

10. Date you last consulted your physician:

11. Name and address of your physician(s):

Additional Information:

Date: _____ Insured's Signature: _____