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

MULTIPLE SCLEROSIS 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. Please list date of first diagnosis:

2. Please indicate the number of episodes and date of last episode:

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

4. Please note your current neurologic status and/or symptoms (please circle):
   normal
   minimal residual impairment (please specify):
   moderate residual impairment (please specify):
   severe residual impairment (please specify):

5. Do you have any other major health problems (i.e. heart disease, etc.)? Yes No
   Details:

6. List name, address & phone number of any doctor(s) and the date last consulted:

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

Date: ____________ Insured's Signature: ____________________