BROOKFIELD PARTNERS

Addison's Disease Questionnaire

UNDERWRITING QUESTIONNAIRE

AGENT & CASE INFORMATION

AGENT NAME | PHONE | E-MAIL

PROPOSED INSURED

CLIENT NAME | DATE OF BIRTH | STATE

HEIGHT | WEIGHT | FACE AMOUNT

Sex: ☐ Male ☐ Female

Tobacco / Nicotine Use: ☐ Yes ☐ No

COVERAGE REQUESTED

Type of Insurance: ☐ Universal Life ☐ Whole Life ☐ Survivorship

☐ Term — number of years:

QUESTIONNAIRE

1. When was the proposed insured first diagnosed with Addison's Disease?

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

☐ Fatigue ☐ Weight loss ☐ Loss of appetite

☐ Nausea ☐ Vomiting ☐ Diarrhea

☐ Hyperpigmentation ☐ Lightheadedness or fainting ☐ Shakiness

☐ Low blood sugar ☐ Difficulty concentrating ☐ Depression

☐ Other

3. Has the proposed insured received any of the following treatments?

☐ Hormone replacement (cortisol and/or aldosterone)

☐ Increased salt intake

☐ Other

4. Is the proposed insured current taking any medication(s)? ☐ Yes ☐ No

If yes, provide name, dosage and frequency of medication(s)