BROOKFIELD PARTNERS

Ankylosing Spondylitis 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 Ankylosing Spondylitis?

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

☐ Pain, stiffness, limited motion in back, hips or neck ☐ Fatigue

☐ Inflammation of the iris

☐ Other

3. Is the proposed insured been disabled as a result of this condition? ☐ Yes ☐ No

If yes, provide dates and monthly disability income:

4. How has the proposed insured been treated for this condition?

☐ Exercise

☐ Medication Name, dosage and frequency:

☐ Physical Therapy Provide frequency:

☐ Assistive Devices; such as canes or walkers

Please e-mail the completed form to Brad Kadelski · brad@brookfieldpartners.com

Brookfield Insurance Partners, LLC · Brookfield, MA · (p) 866-639-0443 · info@brookfieldpartners.com · www.brookfieldpartners.com

☐ Other

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

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