

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 celiac disease?

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

- ☐ Abdominal cramping ☐ Intestinal gas, distention and bloating
☐ Chronic diarrhea and/or constipation ☐ Dental enamel defects
☐ Steatorrhea ☐ Osteopenia or osteoporosis
☐ Anemia ☐ Fatigue
☐ Weight loss ☐ Infertility
☐ Depression ☐ Aphthous ulcers
☐ Dermatitis herpetiformis
☐ Other

3. Is the proposed insured disabled as a result of this condition?

☐ Yes ☐ No

If yes, provide details:

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

4. Is the proposed insured currently taking any medication(s)?

☐ Yes ☐ No

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