BROOKFIELD PARTNERS

Cerebral Palsy 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. What type of Cerebral Palsy has been diagnosed?

☐ Dyskinetic ☐ Ataxic ☐ Spastic

2. When was the proposed insured diagnosed?

3. Which of the following symptoms does the proposed insured experience? (Check all that apply.)

- ☐ Abnormal sensations and perceptions
- ☐ Skin irritation
- ☐ Dental problems
- ☐ Accidents due to muscle control/strength
- ☐ Infection
- ☐ Long term illnesses
- ☐ Other

4. Has the proposed insured experienced any of the following complications? (Check all that apply.)

☐ Joint problems ☐ Bowel and bladder problems

☐ Choking ☐ Acid Reflux

☐ Slowed growth

5. Has the proposed insured ever been disabled as a result of this condition? ☐ Yes ☐ No

If yes, provide details:

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

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