BROOKFIELD PARTNERS

Chiari Malformation 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 type of Chairi Malformation has been diagnosed?

- ☐ Type 1 Date of diagnosis:
- ☐ Type 2 Date of diagnosis:
- ☐ Type 3 Date of diagnosis:
- ☐ ACM2 Date of diagnosis:
- ☐ ACM2 Date of diagnosis:
- ☐ ACM3 Date of diagnosis:

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

- ☐ Headache
- ☐ Vomiting
- ☐ Difficulty swallowing and/or hoarseness
- ☐ Dizziness
- ☐ Impaired ability to coordinate movement
- ☐ Double vision

- [ ] Involuntary rapid downward eye movements
- [ ] Other

3. Has surgery been done or recommended for this condition? ☐ Yes ☐ No

If yes, provide details:

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

If yes, provide details:

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

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