BROOKFIELD PARTNERS

Chronic Fatigue Syndrome 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 diagnosed with Chronic Fatigue Syndrome?

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

- ☐ Forgetfulness, memory loss, confusion, difficulty concentrating
- ☐ Sore throat
- ☐ Tender lymph nodes in the neck or armpits
- ☐ Muscle pain
- ☐ Joint pain
- ☐ New headaches
- ☐ Un-refreshed sleep
- ☐ Fatigue that lasts more than 24 hours
- ☐ Other

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

- ☐ Medication Date and 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

☐ Exercise Program Date and details:

☐ Cognitive behavioral therapy Date and 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):