BROOKFIELD PARTNERS

Grave's Disease 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 Grave's Disease?

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

- ☐ Weight loss despite increased appetite
- ☐ Excessive perspiration
- ☐ Faster heart rate, higher blood pressure
- ☐ Increased sensitivity to heat
- ☐ More frequent bowel movements
- ☐ Muscle weakness, trembling hands
- ☐ Development of a goiter
- ☐ Bulging eyes
- ☐ In women, change if frequency or total cessation of menstrual periods
- ☐ Other

3. Has the proposed insured been diagnosed with any of the following conditions

- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ Grave's ophthalmopathy

4. Is the proposed insured being treated for any other health conditions? ☐ Yes ☐ No

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

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

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

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