BROOKFIELD PARTNERS

Huntington's Chorea 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 Huntington's Chorea?

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

- ☐ Involuntary movements or rigidity
- ☐ Changes in mental status (irritability, moodiness, depression, antisocial behavior)
- ☐ Weight loss
- ☐ Dementia
- ☐ Seizures
- ☐ Other

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

If yes, provide details:

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

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