BROOKFIELD PARTNERS

Mental Disorders 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. Describe the proposed insured's condition and give the diagnosis.

2. What was the date of first symptoms?

3. When did the proposed insured last see a doctor for this condition?

4. Has the proposed insured been hospitalized? ☐ Yes ☐ No

If yes, list all hospitalizations with dates:

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

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5. Is the proposed insured currently employed? ☐ Yes ☐ No

If yes, provide occupation and length of employment:

6. Has the condition interfered with work? ☐ Yes ☐ No

If yes, for how long?

7. Is the proposed insured disabled? ☐ Yes ☐ No

If yes, provide details:

8. When was the last medication adjustment made, and what changed?

9. Are there any other health issues? ☐ Yes ☐ No

If yes, provide details. Additional questionnaires may be required.

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

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