BROOKFIELD PARTNERS

Multiple Sclerosis 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 Multiple Sclerosis?

2. What was the diagnosis?

☐ Relapsing-remitting MS ☐ Secondary Progressive MS

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

☐ Muscle (weakness, stiffness, clumsiness, ataxia)

☐ Visual (blurred, foggy or hazy vision, eye pain, optic neuritis)

☐ Sensory (tingling, numbness, tightness in the trunk or limbs)

☐ Vertigo

☐ Bladder (urinary incontinence, loss of bladder sensation)

☐ Tremor

☐ Pain

☐ Constipation

☐ Cognitive (memory loss, difficulty concentrating, reduced attention span, difficulty finding correct words)

- [ ] Depression and/or anxiety
- [ ] Other

4. Is the proposed insured 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)