BROOKFIELD PARTNERS

Muscular Dystrophy 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 Muscular Dystrophy?

2. What was the diagnosis?

☐ Myotonic ☐ Duchenne ☐ Becker ☐ Limb-girdle ☐ Congenital

☐ Distal ☐ Emery-Dreifuss ☐ Facioscapulohumeral ☐ Oculopharyngeal

3. Which of the following symptoms does the proposed insured experience? (Check all that apply.)

☐ Muscle weakness ☐ Muscle spasms or stiffening after use

☐ Hand weakness ☐ Foot drop

☐ Clumsiness ☐ Frequent falling

☐ Difficulty getting up ☐ Waddling gait

☐ Curvature of the spine

☐ 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)