BROOKFIELD PARTNERS

Myasthenia Gravis 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. What form of Myasthenia Gravis doers the proposed insured have?

- ☐ Generalized Myasthenia Gravis Date of diagnosis:
- ☐ Ocular Myasthenia Gravis Date of diagnosis:
- ☐ Transitory Neonatal Myasthenia Gravis Date of diagnosis:
- ☐ Familial Infantile (Congenital) Myasthenia Gravis Date of diagnosis:
- ☐ Congenital Myasthenia Gravis Date of diagnosis:

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

- ☐ Weakness and drooping of the eyelids (ptosis
- ☐ Weakness of eye muscles
- ☐ Excessive muscle fatigue following activity
- ☐ Weakness of facial muscles
- ☐ Impaired articulation of speech (dysarthria)
- ☐ Difficulties chewing and swallowing
- ☐ Weakness of the upper arms and legs
- ☐ Other

3. Is the proposed insured disabled as a result of this condition? ☐ Yes ☐ No

If yes, provide details:

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

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