



Post-Traumatic Stress Disorder 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 post-traumatic stress disorder?

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

☐ Reliving the event ☐ Anxiety ☐ Panic attacks

☐ Psychosis ☐ Difficulty sleeping ☐ Outbursts of anger or irritability

☐ Difficulty concentrating

☐ Fear for your safety

☐ Other

3. Has the proposed insured ever been hospitalized as a result of this condition?

☐ Yes ☐ No

If yes, provide details:

4. Has the proposed insured ever been disabled as a result of this condition?

☐ Yes ☐ No

If yes, what is the monthly disability income?

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

5. How is the proposed insured being treated for this condition?

- ☐ Medication Name, dosage & frequency:
- ☐ Therapy Frequency of visits
- ☐ Other

6. Has the proposed insured every attempted suicide?

☐ Yes ☐ No

7. Does the proposed insured have any history of substance abuse?

☐ Yes ☐ No

If yes, provide details:

8. Is the proposed insured currently taking any medication(s)?

☐ Yes ☐ No

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