BROOKFIELD PARTNERS

Spina Bifida 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?

2. What type of aneurysm was diagnosed?

- ☐ Spina bifida occulta
- ☐ Spina bifida manifesta

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

- ☐ Dimple, depression or birthmark over affected vertebrae
- ☐ Difficulty walking
- ☐ Bladder control problems
- ☐ Coordination problems
- ☐ Paralysis in legs
- ☐ Other

4. How has the proposed insured been treated?

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

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