BROOKFIELD PARTNERS

Stroke 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. Which of the following did the proposed insured experience?

☐ Stroke (CVA) Date(s):

☐ Mini Stroke (TIA) Date(s):

2. What follow-up studies were done following the stroke or mini stroke?

☐ CT Scan ☐ MRI Scan ☐ Carotid ultrasound ☐ Echocardiogram

☐ Other

3. Has the proposed insured been diagnosed with any of the following conditions? (Check all that apply.)

☐ Hypertension Most current reading:

☐ Elevated Cholesterol Most current reading:

☐ Heart Attack Date(s):

☐ Diabetes Date of diagnosis: Sugar:

Most recent A1C test result:

☐ Coronary Artery Disease (CAD) Date of diagnosis:

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

Details:

☐ Peripheral Vascular Disease Date of diagnosis:

Details:

☐ Valve Disorders Date of diagnosis:

Details:

☐ Cardiomyopathy Date of diagnosis:

Details:

☐ Atrial Fibrillation Date of diagnosis:

Details:

☐ Other

4. Describe any residual neurologic deficits or other residual effects from the stroke or mini stroke:

5. Does the proposed insured have any other medical conditions? ☐ Yes ☐ No

If yes, provide details:

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

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