BROOKFIELD PARTNERS

Von Willebrand's Disease 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 Von Willebrand's Disease?

2. What classification of Von Willebrand's Disease was diagnosed?

☐ Type 1 ☐ Type 2 ☐ Type 3

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

☐ Frequent bloody nose ☐ Bleeding from the gums

☐ Blood in the urine ☐ Bruising easily

☐ Black, tarry or blood stools ☐ Bleeding into joints

☐ In women, heavy menstrual periods

☐ Other

4. Has the proposed insured received any of the following treatments?

☐ Desmopressin medication Details:

☐ Clotting factor replacement therapies Details:

☐ Antifibrinolytic agents Details:

- ☐ Hormone therapy Details:
- ☐ Topical medication Details:
- ☐ Other

5. Does the proposed insured know the results of the following tests?

- ☐ Prothrombin Time Details:
- ☐ Partial thromboplastin time Details:

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

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