BROOKFIELD PARTNERS

Wegener's Granulomatosis 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 Wegener's Granulomatosis?

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

☐ Upper respiratory symptoms ☐ Joint Pains ☐ Weakness

☐ Skin Lesions ☐ Fever ☐ Night sweats

☐ Conjunctivitis ☐ Scleritis ☐ Episcleritis

☐ Other

3. Have any of the following been affected by this condition?

☐ Lungs ☐ Kidneys ☐ Musculoskeletal System ☐ Eyes ☐ Skin

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

☐ Prednisone Details:

☐ Cyclophosphamide Details:

☐ Azathioprine Details:

☐ Methotrexate Details:

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

- ☐ Bactrim or Septra Details:
- ☐ Leucovorin Details:
- ☐ Other

5. Is the proposed insured disabled as a result of this condition? ☐ 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)