



An insurance Designers member since 1986

# PARKINSONISM / PARKINSON'S DISEASE QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of birth: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_ / year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):  Y  N

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: \_\_\_\_ (Month) \_\_\_\_ (Year) Type used last: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

(1) *Date of first diagnosis:* \_\_\_\_\_

(2) *Describe current symptoms:* \_\_\_\_\_

(3) *Does the proposed insured take any medications or have any been taken in the past?*  No  Yes; please list in table:

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) *Has any surgery been done?*  No  Yes; please describe: \_\_\_\_\_

(5) *Is the proposed insured independent (could live alone, without assistance)?*  Yes  No; list extent of the disability: \_\_\_\_\_

(6) *Is the proposed insured receiving disability payments due to inability to work full time?*

No  Yes; since (date): \_\_\_\_\_

(7) *Is the proposed insured participating in any kind of experimental treatment program?*  No  Yes; please describe: \_\_\_\_\_

(8) *Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_