

Autism & Asperger's Questionnaire - Tentative offers obtained are not binding and could be subject to change – Final offers are subject to formal application and review of all required age/face requirements, paramedical requirements and review of complete medical records.

Agent/Advisor Name: _____
Proposed Insured: _____ Date Of Birth: _____ Gender: Male or Female
Build: Height _____ Weight _____ Any Weight Loss In Last Year? If so how much _____
Product Desired: Term Guarantee UL Index UL Whole Life Survivorship Life
Face Amount Desired: Option 1 \$ _____ Option 2 \$ _____ Option 3 \$ _____
Maximum Premium Tolerance Per Year: _____
Has Client Ever Used Any Form Of Nicotine? No Yes
Type: Cigarettes Cigars Pipe Chew Patch Nicorette Gum E-Cigarette Vape
Frequency: _____ Date Last Used _____
Current Alcohol Use: Type _____ Number of Drinks: _____ Per _____ Day _____ Week Date Last Used: _____

- 1) What was your date of diagnosis? _____ Your age at onset? _____
- 2) What was the official diagnosis for Autism and or Asperger's?

- 3) Have any psychiatric disorders been diagnosed? Yes No If yes; provide details

- 4) Have any intellectual disability been diagnosed? Yes No If yes; provide details

- 5) Are physical impairments present? Yes No If yes; select from below and provide details
 Cerebral palsy describe level of function

 Seizure History state type and frequency

- 6) Are activities of daily living (ADL's) or instrumental activities of daily living (IADL's) appropriate for age?
ADLS appropriate for age (e.g., ambulating, toileting, bathing, feeding, dressing, self-care)
 Yes
 No. Provide details

IADLS appropriate for age (e.g., cooking, housecleaning, telephone use, driving)
 Yes
 No. Provide details

- 7) Are you working or in school? Yes No Please give details for either answer

- 8) Are you currently on disability for this condition? Yes No If yes; provide complete details, dates and duration

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9) If minor, is the minor in regular class for age? Yes No If No; provide details

10) Is there family history of heart disease or cancer? Yes No If yes; provide details including relationship to yourself, age of onset, type and current age or date of death

11) Have you made any lifestyle changes to improve your overall health? Yes No If yes; provide details

12) Are you being treated for any other medical conditions? If yes; provide details

13) Please list all other current medications, dosages and what condition the medication is treating

Please use additional pages if needed