Multiple Sclerosis 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) Provide date of diagnosis? ____
2) How was the condition diagnosed?
   ☐MRI ☐Evoked Potentials ☐Blood tests ☐Lumbar puncture (spinal tap) ☐Other:_______________________
3) Is the multiple sclerosis active? ☐Yes ☐No
4) Please complete the table as much as possible:

Date of Attack(s)	Duration of the attack(s)	Residual Effects	Specify Impairment for Residual Effects
		☐None ☐Minimal ☐Moderate ☐Severe	
		☐None ☐Minimal ☐Moderate ☐Severe	
		☐None ☐Minimal ☐Moderate ☐Severe	
		☐None ☐Minimal ☐Moderate ☐Severe	

5) Is there disability, please provide the score for the Expanded Disability Status Scale (EDSS) or otherwise describe the disability:
   EDSS Score: _____________ (0 through 10) or Description: ____
6) What is the degree of severity of your multiple sclerosis?
   ☐Mild – total 2 to 4 mild exacerbations with no residuals
   ☐Moderate – slowing progressive, one or two attacks per year with recovery between attacks, some moderate residuals, such as cane use
   ☐Severe – progressive, more than two attacks per year, wheel chair confinement, bedridden
   ☐Rapidly progressing symptoms
7) Current symptoms (check all that have occurred over the past two years)
   ☐Visual difficulties ☐Numbness ☐Weakness or fatigue ☐Impaired swallowing ☐Frequent bladder infections
   ☐Bowel control difficulties ☐Use of Cane ☐Use of wheel chair ☐Difficulty with speech
8) When did you last seen your physician for this condition?
   ☐0 to 6 months ago ☐6 to 12 months ago ☐1 to 2 years ago ☐Over 2 years ago
9) Are you receiving disability payments due inability to work fulltime? ☐Yes ☐No If yes; specify since when?
   ____
   ____
10) Do you take any type of maintenance medication to treat your condition? ☐Yes ☐No If yes; please provide name, dosage and frequency of each medication treating your multiple sclerosis:
   ____
   ____
11) Are you participating in any kind of experimental treatment program? ☐Yes ☐No If yes; provide details
   ____
   ____

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12) Have you had any surgery to treat your multiple sclerosis? ☐Yes ☐No If yes; please describe:

13) 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

14) Do you exercise three or more times per week on a regular basis? ☐Yes ☐No if yes provide details

15) Have you made any lifestyle changes to improve your overall health? ☐Yes ☐No if yes provide details

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

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

Please use additional pages if needed

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