

MULTIPLE SCLEROSIS 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. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N

If Yes, please provide details: _____

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

(1) *Date of first diagnosis:* _____

(2) *How was the condition diagnosed?* MRI Evoked Potentials Other: _____

(3) *Please complete the following table as much as possible:*

Approximate Date of Attack(s)	Duration of the Attack(s)	Residual Effects	Specify Impairment for Residual Effects
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
		<input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	

(4) *Is there is disability, please provide the score for the Expanded Disability Status Scale (EDSS) or otherwise describe the disability:*

EDSS Score: _____ (0 through 10) *or* Description: _____

(5) *Does the proposed insured take any medications?* No Yes (please list below)

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

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