Down's Syndrome Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. Does the proposed insured suffer from or have a history of any of the following: (check all that apply):
___Heart disease or defect ___Digestive system problems ___Eye problems
___Alzheimer's disease ___Childhood leukemia

2. Is, the proposed insured, disabled as a result of this condition? ___Yes ___No

3. Does the proposed insured live independently? ___Yes ___No

4. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide name, dosage, and frequency):
_____
_____
_____
_____

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