Guillain-Barré Syndrome Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with Guillain-Barré Syndrome? _____

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

___ Numbness or tingling in hands or feet
___ Muscle weakness
___ Difficulty speaking, chewing, swallowing
___ Back pain
___ Numbness or tingling around mouth/lips
___ Loss of reflexes
___ Inability to move eyes
___ Other: _____

3. Has the proposed insured ever received immunotherapy treatment for this condition? ___ Yes ___ No
If yes, provide details: _____
_____

4. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
If yes, provide name, dosage and frequency of medication(s) _____
_____
_____

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