Multiple Sclerosis 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 Multiple Sclerosis? _____

2. What was the diagnosis? ___ Relapsing-remitting MS ___ Secondary Progressive MS

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

   ___ Muscle (weakness, stiffness, clumsiness, ataxia)
   ___ Visual (blurred, foggy or hazy vision, eye pain, optic neuritis)
   ___ Sensory (tingling, numbness, tightness in the trunk or limbs)
   ___ Vertigo
   ___ Bladder (urinary incontinence, loss of bladder sensation)
   ___ Tremor
   ___ Pain
   ___ Constipation
   ___ Cognitive (memory loss, difficulty concentrating, reduced attention span, difficulty finding correct words)
   ___ Depression and/or anxiety
   ___ Other: _____

4. Is the proposed insured disabled as a result of this condition? ___ Yes ___ No
   If yes, provide details: _____
   _____

5. 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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