Spina Bifida 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? _____

2. What type of aneurysm was diagnosed?

   ___ Spina bifida occulta
   ___ Spina bifida manifesta

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

   ___ Dimple, depression or birthmark over affected vertebrae
   ___ Difficulty walking
   ___ Bladder control problems
   ___ Coordination problems
   ___ Paralysis in legs
   ___ Other: _____

4. How has the proposed insured been treated? _____
   _____

6. 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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