Narcolepsy Questionnaire

Name: ________________________ Date of Birth: _________________

Height: ________ Weight: _______ Sex: M/ F

Tobacco Usage: ________________ Face Amount: ________________

___Term 10 15 20 30 __UL

1. When was the proposed insured diagnosed with Narcolepsy? ________________________

2. Which of the following symptoms has the proposed insured experienced now or in the past?

   ___ Excessive daytime sleepiness
   ___ sudden loss of muscle tone
   ___ Sleep paralysis
   ___ Hallucinations

3. Has the proposed insured had any of the following tests? ___Yes ___No
   (If so, provide dates and results)
   ___ Actigraphy Date: __________ Results: __________________________
   ___ Polysomnogram Date: __________ Results: __________________________
   ___ Multiple sleep latency test Date: __________ Results: __________________________

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

5. Has the proposed insured taken any medication for this condition in the past? ___Yes ___No
   (If yes, please provide name, frequency, and dosage):
   ____
   ____
   ____

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

7. Does the proposed insured have a valid, active driver's license? ___Yes ___No

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787