Attention Deficit Disorder 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 first diagnosed? ____

2. What specific condition has the proposed insured been diagnosed with?

   ___Attention Deficit Disorder ___Attention Deficit Hyperactivity Disorder

3. Has the proposed insured ever been hospitalized as a result of this condition? ___Yes ___No
(If yes, please provide details):____
____
____

4. Has the proposed insured ever been disabled as a result of this condition? ___Yes ___No
(If yes, what is their monthly disability income? ____

5. How is, the proposed insured, being treated for this condition?

   ___Medication (Please provide name, dosage, and frequency):
   ____

   ___Therapy (If yes, please provide frequency of visits):
   ____

   ___Other (Please describe):
   ____

6.Is the proposed insured taking medications for this condition or any other? ____Yes ____No
(If yes, please provided name of medication, dosage, and frequency) _____________________________
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