Lyme Disease 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 Lyme's Disease?

_____

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

___Fatigue ___Fever and chills ___Muscle and Joint Pain
___Headache and stiff neck ___Swollen lymph nodes ___Other (please explain)

3. Are the skin, joints, nervous system and/or heart affected by Lyme disease? ___Yes ___No
Details: _____

_____

4. Does, the proposed insured, have any other health conditions for which they receive ongoing Treatment? _____

_____

5. Is, the proposed insured, disabled as a result of this condition? ___Yes ___No
(If yes, please provide the date(s) of disability and monthly disability income)

_____

_____

6. Is the proposed insured taking any medication? ___Yes ___No
(If yes, please provide name, dosage, and frequency)

_____

_____

_____

_____

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