



Protecting your family.
For Life!

MULTIPLE SCLEROSIS QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____
Face Amount: _____ Max. Premium: \$ _____ /year UL WL Term Survivorship
Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N
If Yes, please provide details: _____
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

(1) Date of first diagnosis: _____ Definite MS diagnosis? Or Possible MS?

(2) How has the condition been diagnosed?

- Relapsing Remitting Primary Progressive Secondary Progressive Progressive Relapsing

(3) How is it being treated? _____

(4) If there is disability, please provide the score for the Expanded Disability Status Scale (EDSS) or otherwise describe the disability:

EDSS Score: _____ (0 through 10) or Description: _____

(5) How would your doctor characterize the severity? Mild Moderate Severe

(6) Does the proposed insured take any medications? No Yes (please list below)

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(7) What is the average number of attacks per year? _____ Any related depression? Yes No

(8) Any documented remission? Yes No Or diagnosis of Benign MS? Yes No

(9) Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:

