

MULTIPLE SCLEROSIS QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
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Proposed Insured Name: _____	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth: _____
Face Amount: _____	Max. Premium: \$ _____/year	<input type="checkbox"/> UL	<input type="checkbox"/> WL
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N		If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____	
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):		<input type="checkbox"/> Y <input type="checkbox"/> 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:
