

**PARKINSONISM/PARKINSON'S DISEASE 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:* \_\_\_\_\_

(2) *Describe current symptoms:* \_\_\_\_\_  
 \_\_\_\_\_

(3) *Does the proposed insured take any medications or have any been taken in the past?*  No  Yes; please list in table:

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

(4) *Has any surgery been done?*  No  Yes; please describe: \_\_\_\_\_  
 \_\_\_\_\_

(5) *Is the proposed insured independent (could live alone, without assistance)?*  Yes  No; list extent of the disability:

(6) *Is the proposed insured receiving disability payments due to inability to work full time?*  No  Yes; since (date): \_\_\_\_\_

(7) *Is the proposed insured participating in any kind of experimental treatment program?*  No  Yes; please describe: \_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_