

## DEMENTIA & ALZHEIMER'S DISEASE QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
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 <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
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 initial professional diagnosis or reports in APS data regarding "memory loss" or similar:* \_\_\_\_\_

(2) *Approximate date of onset of symptoms as reported by proposed insured:* \_\_\_\_\_

(3) *Name of the type of dementia diagnosed:* \_\_\_\_\_

(4) *Please check all of the following activities your customer still does regularly and independently:*

- Manages financial affairs     Drives a car     Buys groceries     Has an active social life with friends, relatives

(5) *Please indicate the impact of the dementia for the proposed insured:*

- Occasional forgetfulness only
- Moderate forgetfulness, but still fully functional and living independently
- Needs daily supervision to do every day things, such as taking medicine
- Can no longer function independently; no longer able to drive; acts disoriented
- Assistance needed with any Activity of Daily Living
- Legal guardianship assigned to someone else

(6) *Are there any other medical conditions, such as high blood pressure, diabetes, heart disease, or cancer? If yes, describe:*

\_\_\_\_\_

\_\_\_\_\_

(7) *Are there any factors that may be relevant to assessment of the insurability of this individual? If yes, please list:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(8) *Does the proposed insured take any medications for any reason? If yes, please list:*

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