



Alzheimer's Questionnaire

Agent Name: _____ Phone #: _____ ()

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: \$ _____ Type of Insurance: UL WL SUL Term (# of years _____)

1. When was the proposed insured first diagnosed with Alzheimer's? _____

2. What was the diagnosis?

- Early Onset Alzheimer's (diagnosed prior to age 65)
- Late Onset Alzheimer's (most common – diagnosed after age 65)
- Familial Alzheimer's Disease (FAD)

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

- | | |
|--|---|
| <input type="checkbox"/> Short term memory loss | <input type="checkbox"/> Long term memory loss |
| <input type="checkbox"/> Inability to use judgment/make decisions | <input type="checkbox"/> Loss of language skills |
| <input type="checkbox"/> Difficulty learning/remembering new information | <input type="checkbox"/> Decline in ability to perform everyday tasks |
| <input type="checkbox"/> Other: _____ | |

4. Is the proposed insured currently able to perform everyday tasks without assistance? Yes No

If no, provide details: _____

4. Is the proposed insured current taking any medication(s)? Yes No

If yes, provide name, dosage and frequency of medication(s) _____

FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com