Ankylosing Spondylitis 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 Ankylosing Spondylitis? _____

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

   ___ Pain, stiffness, limited motion in back, hips or neck ___ Fatigue
   ___ Inflammation of the iris ___ Other: _____

3. Is the proposed insured been disabled as a result of this condition? ___ Yes ___ No
   If yes, provide dates and monthly disability income: _____
   _____

4. How has the proposed insured been treated for this condition?

   ___ Exercise
   ___ Medication Name, dosage and frequency: _____
   ___ Physical Therapy Provide frequency: _____
   ___ Assistive Devices; such as canes or walkers
   ___ Other: _____

5. 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