



# Barrett's Esophagus 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 Barrett's Esophagus? \_\_\_\_\_

2. Has the proposed insured ever had an Endoscopy/Biopsy?  Yes  No  
If yes, when? \_\_\_\_\_  
Did the test indicate dysplasia?  Yes  No

3. Has the proposed insured ever experienced any of the following symptoms? (Check all that apply.)  
 Frequent heartburn  Weight loss  
 Pain  Difficulty swallowing  
 Other: \_\_\_\_\_

4. Is the proposed insured current taking any medication(s)?  Yes  No  
If yes, provide name, dosage and frequency of medication(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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