Celiac Disease 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 _____)

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1. When was the proposed insured first diagnosed with celiac disease? ______________________________

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

   ___ Abdominal cramping
   ___ Chronic diarrhea and/or constipation
   ___ Steatorrhea
   ___ Anemia
   ___ Weight loss
   ___ Depression
   ___ Dermatitis herpetiformis
   ___ Intestinal gas, distention and bloating
   ___ Dental enamel defects
   ___ Osteopenia or osteoporosis
   ___ Fatigue
   ___ Infertility
   ___ Aphthous ulcers
   ___ Other: ______________________________

3. Is the proposed insured disabled as a result of this condition? ___ Yes ___ No
   If yes, provide details: ______________________________
   ____

4. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) ______________________________
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   ____
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FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com