



Chrohn's Disease / Colitis / Diverticulitis 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. What was the proposed insured's diagnosis?

Crohn's Disease Colitis Diverticulitis

Date of first diagnosis: _____

Date of most recent episode: _____

Total number of episodes: _____

2. Number of episodes in the past six months: _____ Longest duration: _____ (days, weeks, months)

3. Number of episodes in the past five years: _____ Longest duration: _____ (days, weeks, months)

4. What condition(s) have been diagnosed? (Check all that apply.)

<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Frequent colon spasms	<input type="checkbox"/> Frequent diarrhea
<input type="checkbox"/> Ulcerative Proctitis	<input type="checkbox"/> Mucous Colitis	<input type="checkbox"/> Spastic Colitis
<input type="checkbox"/> Catarrhal Colitis	<input type="checkbox"/> Ulcerative Proctosigmoiditis	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Chronic Proctitis (rectum)	<input type="checkbox"/> Chronic Ulcerative Colitis	<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Other: _____		

5. Has the proposed insured ever been hospitalized for the condition? Yes No

If yes, provide date(s): _____

6. Has surgery been done? Yes No

If yes, provide date and type of surgery: _____

If no, has surgery been recommended? Yes No

If yes, when will the surgery be complete: _____

7. Has the proposed insured ever been disabled because of the condition? Yes No

If yes, provide details and dates: _____

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

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

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