Muscular Dystrophy 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 Muscular Dystrophy? _____

2. What was the diagnosis?

___ Myotonic ___ Duchenne ___ Becker ___ Limb-girdle ___ Congenital
___ Distal ___ Emery-Dreifuss ___ Facioscapulohumeral ___ Oculopharyngeal

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

___ Muscle weakness
___ Hand weakness
___ Clumsiness
___ Difficulty getting up
___ Curvature of the spine
___ Muscle spasms or stiffening after use
___ Foot drop
___ Frequent falling
___ Waddling gait
___ Other: _____

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

5. 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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