Myasthenia Gravis 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. What form of Myasthenia Gravis doers the proposed insured have?

___ Generalized Myasthenia Gravis	Date of diagnosis: _____
___ Ocular Myasthenia Gravis	Date of diagnosis: _____
___ Transitory Neonatal Myasthenia Gravis	Date of diagnosis: _____
___ Familial Infantile (Congenital) Myasthenia Gravis	Date of diagnosis: _____
___ Congenital Myasthenia Gravis	Date of diagnosis: _____

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

___ Weakness and drooping of the eyelids (ptosis	___ Weakness of eye muscles
___ Excessive muscle fatigue following activity	___ Weakness of facial muscles
___ Impaired articulation of speech (dysarthria)	___ Difficulties chewing and swallowing
___ Weakness of the upper arms and legs	___ 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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