

Nervous Disorders/Dementia Questionnaire

Agent Name _____ Phone _____

Email Address _____

Applicant Last Name _____ Date of Birth _____

Sex Male Female Height/Weight _____ / _____

Occupation _____ Ever use nicotine products? _____

If yes, select type : Cigarettes Cigar Chewing tobacco Other: _____

Date last used _____ Frequency per month _____

Product Applying for: Term Universal Face Amount _____

1. What is your medical diagnosis and date diagnosed? _____
2. What were your first symptoms? _____
3. Is the disease mild and slowly progressive? No Yes, details _____
4. Has there been any deterioration in your memory? No Yes; details _____
5. Check all the following that apply. I'm able to:
 Care for myself Handle my own finances Live on my own Handle my legal affairs

6. List of diagnostic tests:

Name of Test	Date performed	Results

7. Please list all medications you are currently taking:

Name of Medication	Dosage	Reason

8. Please list name of physicians and date last seen:

Name of physician	Location	Date last seen

Please fax this form to MRW Financial Inc. 813-875-7331 or email to marie@mrwfinancial.com