



NEUROMUSCULAR DISORDER

CLIENT NAME: _____ **Date:** _____
 Male Female Date of birth: _____ Height: _____' _____" Weight: _____
Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____
Type of Coverage: Term UL Survivor Disability **Coverage Amount:** _____
Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____
Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE

Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

- List date of first diagnosis: _____
- Name of neuromuscular disorder: _____
- Describe condition at diagnosis. _____

- What is the current status of the condition (e.g., stable, progressed, etc.)? _____

- Does the client have any associated impairments in functioning? No Yes
- Does client use a cane or a wheelchair? No Yes
- Does client have a caregiver? No Yes
- Is client receiving any treatment? No Yes, What type? _____
- When did client last see doctor for this condition? _____
- List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

- Are there any other health problems? (additional questionnaires may be required) No Yes; please give details

