

## COLITIS & CROHN'S DISEASE QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$\_\_\_\_\_/year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_  
 Height: \_\_\_\_ft. \_\_\_\_in. Weight: \_\_\_\_lbs.

(1) *Date of first diagnosis:* \_\_\_\_\_ *Date of most recent episode:* \_\_\_\_\_ *Total Number. of episodes:* \_\_\_\_\_

*Number of episodes past six months:* \_\_\_\_\_ *Longest duration:* \_\_\_\_\_ (days, weeks, months)

*Number of episodes past five years:* \_\_\_\_\_ *Longest duration:* \_\_\_\_\_ (days, weeks, months)

(2) *What condition(s) have been diagnosed?*

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Irritable Bowl 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"/> Chronic Proctitis (rectum) | <input type="checkbox"/> Chronic Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease   | <input type="checkbox"/> Other: _____                 |

(3) *Is the proposed insured taking any medications? If yes:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) *Has the proposed insured ever been hospitalized for the condition? If yes, please provide date(s):* \_\_\_\_\_

(5) *Has surgery been recommended? If yes, when will the surgery be completed?* \_\_\_\_\_

(6) *Has surgery been done? If yes, please list dates and type of surgery(ies):* \_\_\_\_\_

(7) *Has the proposed insured ever been disabled because of the condition? If yes, dates:* \_\_\_\_\_

(8) *Does the proposed insured have any other medical conditions that may affect underwriting? If yes, please provide details:*

\_\_\_\_\_

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\_\_\_\_\_