Cenco Insurance Marketing Corporation
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Questionnaire For: Multiple Sclerosis

Information gathered will be used in the evaluation of the insurability of the applicant. Offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

Agent's Name: ____________________________________Phone #: ______________________
Proposed Insured: _________________________________Date of Birth: ___/___/_____
Male ( ) Female ( ) Height ______Weight ______ Smoker ( ) Non Smoker ( )
Amount of Coverage $_____________ Product Type _____________________________

1. Date multiple sclerosis was diagnosed ________________________________

2. Is multiple sclerosis active? [ ] Yes [ ] No
   If yes, what is the date of last attack _________________________________

3. What is the degree of severity of multiple sclerosis?
   [ ] Mild – total 2 to 4, mild exacerbations with no residuals
   [ ] Moderate – slowly progressive, one or two attacks per year with recovery between attacks, some moderate residuals, such as cane use
   [ ] Severe – progressive, more than 2 attacks per year, wheel chair confinement, bedridden
   [ ] Rapidly progressing symptoms

4. Current symptoms (check all that have occurred over the past two years):
   [ ] Visual difficulties
   [ ] Numbness
   [ ] Weakness or fatigue
   [ ] Impaired swallowing
   [ ] Frequent bladder infections
   [ ] Bowel control difficulties
   [ ] Use of cane
   [ ] Use of wheel chair
   [ ] Difficulty with speech

5. Date of client's last visit to a physician:
   [ ] 0 to 6 months ago
   [ ] 6 to 12 months ago
   [ ] 12 to 24 months ago
   [ ] over 2 years ago

6. List the last cholesterol reading, if known: ___________________HDL Ratio ______________

7. List the last blood pressure reading, if known: ___________Systolic/ _____________Diastolic

8. Has a parent, brother or sister died prior to age 65, other than by accident? [ ] Yes [ ] No
   If yes, please detail ____

9. Does the client exercise three or more times per week? [ ] Yes [ ] No If yes, please details
   ____

10. Client's occupation ____

11. Please list any other illnesses and impairments; along with <u>any and all medications currently being taken</u>, include the dosage and frequency of each: ________________________________
   ____
   ____