

## DEMENTIA & ALZHEIMER'S DISEASE QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____ /year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		

(1) Date of initial professional diagnosis or reports in APS data regarding "memory loss" or similar: \_\_\_\_\_

(2) Approximate date of onset of symptoms as reported by proposed insured: \_\_\_\_\_

(3) Name of the type of dementia diagnosed: \_\_\_\_\_

(4) Please check all of the following activities your customer still does regularly and independently:

- Manages financial affairs   
  Drives a car   
  Buys groceries   
  Has an active social life with friends, relatives

(5) Please indicate the impact of the dementia for the proposed insured:

- Occasional forgetfulness only  
 Moderate forgetfulness, but still fully functional and living independently  
 Needs daily supervision to do every day things, such as taking medicine  
 Can no longer function independently; no longer able to drive; acts disoriented  
 Assistance needed with any Activity of Daily Living  
 Legal guardianship assigned to someone else

(6) Are there any other medical conditions, such as high blood pressure, diabetes, heart disease, or cancer? If yes, describe:

\_\_\_\_\_

\_\_\_\_\_

(7) Are there any factors that may be relevant to assessment of the insurability of this individual? If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(8) Does the proposed insured take any medications for any reason? If yes, please list:

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