

Addison's Disease Questionnaire

Agent Name: _____ Phone #: _____ E-mail: _____
Client Name: _____ Date of Birth: _____ Sex: Male / Female
Height: _____ Weight: _____ State: _____ Smoker: Y / N Face Amount: _____
Type of Insurance: Universal Life Whole Life Survivorship Term (# of years)

1. When was the proposed insured first diagnosed with Addison's Disease? _____

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Lightheadedness or fainting	<input type="checkbox"/> Shakiness
<input type="checkbox"/> Low blood sugar	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Depression
<input type="checkbox"/> Other: _____		

3. Has the proposed insured received any of the following treatments?

Hormone replacement (cortisol and/or aldosterone)
 Increased salt intake
 Other: _____

4. Is the proposed insured current taking any medication(s)? Yes No
If yes, provide name, dosage and frequency of medication(s) _____

FAX TO 603-778-7918 or E-MAIL TO sdonovan@uinc.com.