

Barrett's Esophagus 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 Barrett's Esophagus? _____

2. Has the proposed insured ever had an Endoscopy/Biopsy? Yes No
If yes, when? _____
Did the test indicate dysplasia? Yes No

3. Has the proposed insured ever experienced any of the following symptoms? (Check all that apply.)

<input type="checkbox"/> Frequent heartburn	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Pain	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> 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@uuinc.com.