

Cerebral Palsy 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. What type of Cerebral Palsy has been diagnosed? Dyskinetic Ataxic Spastic

2. When was the proposed insured diagnosed? _____

3. Which of the following symptoms does the proposed insured experience? (Check all that apply.)

- Abnormal sensations and perceptions
- Skin irritation
- Dental problems
- Accidents due to muscle control/strength
- Infection
- Long term illnesses
- Other: _____

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

- Joint problems
- Choking
- Slowed growth
- Bowel and bladder problems
- Acid Reflux

4. Has the proposed insured ever been disabled as a result of this condition? Yes No
If yes, provide details: _____

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

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