

# Eating Disorder 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 \_\_\_\_\_)

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1. When was the proposed insured first diagnosed with an eating disorder? \_\_\_\_\_

2. What was the diagnosis?  Anorexia Nervosa  Bulimia Nervosa  Other: \_\_\_\_\_

3. How many episodes have occurred? \_\_\_\_\_  
Date of last episode/recovery: \_\_\_\_\_

4. Has the proposed insured's weight remained stable for at least 1 year?  Yes  No  
If no, provide details: \_\_\_\_\_  
\_\_\_\_\_

5. Has the proposed insured been hospitalized for treatment of an eating disorder?  Yes  No  
If yes, provide date(s) and details of treatment: \_\_\_\_\_  
\_\_\_\_\_

6. Has the proposed insured been diagnosed with any of the following associated conditions? (Check all that apply.)

Substance abuse (alcohol or drugs)  Personality disorder  
 Psychotic disorder - suicidal thought/attempt  Depression/Anxiety disorder

7. 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](mailto:sdonovan@uinc.com).