

# Guillain-Barré Syndrome 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 Guillain-Barré Syndrome? \_\_\_\_\_

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

- |   |   |
|---|---|
| <input type="checkbox"/> Numbness or tingling in hands or feet    | <input type="checkbox"/> Numbness or tingling around mouth/lips |
| <input type="checkbox"/> Muscle weakness                          | <input type="checkbox"/> Loss of reflexes                       |
| <input type="checkbox"/> Difficulty speaking, chewing, swallowing | <input type="checkbox"/> Inability to move eyes                 |
| <input type="checkbox"/> Back pain                                | <input type="checkbox"/> Other: _____                           |

3. Has the proposed insured ever received immunotherapy treatment for this condition?      Yes      No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

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

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