

Hemochromatosis 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 hemochromatosis? _____

2. When first diagnosed, how many blood draws (phlebotomies, venesections) were done in what time frame?

3. Is the proposed insured now on a regular blood draw schedule? Yes No
If yes, how often? _____
If no, why not? _____

4. Are the proposed insured's liver function tests normal? Yes No
Date of most recent test: _____
Test values were as follows: GGTP: _____ SGOT/AST: _____ SGPT/ALT: _____

5. Have there been any abnormalities or effects on other organs or tissues? Yes No
If yes, provide details: _____

6. 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.