

Huntington's Chorea 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 diagnosed with Huntington's Chorea? _____

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)
 Involuntary movements or rigidity
 Changes in mental status (irritability, moodiness, depression, antisocial behavior)
 Weight loss
 Dementia
 Seizures
 Other: _____

3. Has the proposed insured ever been hospitalized for this condition? Yes No
If yes, provide details: _____

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): _____

FAX TO 603-778-7918 or E-MAIL TO sdonovan@uuinc.com.