

Narcolepsy 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 narcolepsy? _____

2. Has the proposed insured ever experienced any of the following symptoms? (Check all that apply.)

Excessive daytime sleepiness Sudden loss of muscle tone
 Sleep paralysis Hallucinations

3. Has the proposed insured had any of the following tests?

<input type="checkbox"/> Actigraphy	Date & Results: _____
<input type="checkbox"/> Polysomnogram	Date & Results: _____
<input type="checkbox"/> Multiple sleep latency	Date & Results: _____

4. How has the proposed insured been treated for this condition? _____

5. Is the proposed insured disabled as a result of this condition? Yes No
If yes, provide details: _____

6. Does the proposed insured have a valid, active driver's license? Yes No

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@uuinc.com.