

Osteoporosis 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 osteoporosis? _____

2. Has the proposed insured had a bone density test (BMD)? Yes No
If yes, when was the test? _____
T-Scores? _____

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

<u> </u> Fractures	Details & Date: _____
<u> </u> Spinal compression fractures	Details & Date: _____
<u> </u> Low back and/or neck pain	Details & Date: _____

4. 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.