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Schizophrenia 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 Schizophrenia? ____

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

   ___ Apathy or lack of motivation
   ___ Reduced or inappropriate emotion
   ___ Substance abuse
   ___ Hallucinations
   ___ Disorganized or confusing thoughts and speech
   ___ Self-neglect (such as not bathing)
   ___ Depression
   ___ Bipolar disorder
   ___ Delusions
   ___ Other: ____________________________________

3. Has the proposed insured ever been hospitalized as a result of 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 dates and monthly disability income: ______________________________________
   ____

5. How is the proposed insured being treated for this condition?

   ___ Medication Name, dosage and frequency: ____
   ___ Therapy Provide frequency: ____
   ___ Other: ____

6. Has the proposed insured ever attempted suicide? ___ 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.

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