

# Spina Bifida 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? \_\_\_\_\_

2. What type of aneurysm was diagnosed?

- Spina bifida occulta  
 Spina bifida manifesta

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

- Dimple, depression or birthmark over affected vertebrae  
 Difficulty walking  
 Bladder control problems  
 Coordination problems  
 Paralysis in legs  
 Other: \_\_\_\_\_

4. How has the proposed insured been treated? \_\_\_\_\_  
\_\_\_\_\_

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](mailto:sdonovan@uuinc.com).