

Tourette's Syndrome 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? _____

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

- Simple motor tics involving only one muscle group
- Complex motor tics involving a series of movements or muscle groups
- Simple vocal tics involving simple sounds
- Complex vocal tics involving words, phrases and sentences

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

- | | | |
|--|--------------|----------------|
| <input type="checkbox"/> Depression | Dates: _____ | Details: _____ |
| <input type="checkbox"/> Attention Deficit Disorder | Dates: _____ | Details: _____ |
| <input type="checkbox"/> Obsessive Compulsive Disorder | Dates: _____ | Details: _____ |

4. How is the proposed insured being treated? _____

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

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.