

COLITIS & CROHN'S DISEASE QUESTIONNAIRE

Agent: _____ Phone: _____ Fax: _____

Proposed Insured Name: _____ M F Date of Birth: _____

Face Amount: _____ Max. Premium: \$ _____ /year UL WL Term Survivorship

Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____

Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): Y N

If Yes, please provide details: _____

When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

(1) *Date of first diagnosis:* _____ *Date of most recent episode:* _____ *Total Number. of episodes:* _____

Number of episodes past six months: _____ *Longest duration:* _____ (days, weeks, months)

Number of episodes past five years: _____ *Longest duration:* _____ (days, weeks, months)

(2) *What condition(s) have been diagnosed?*

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Irritable Bowl Syndrome | <input type="checkbox"/> Frequent colon spasms | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Ulcerative Proctitis |
| <input type="checkbox"/> Mucous Colitis | <input type="checkbox"/> Spastic Colitis | <input type="checkbox"/> Catarrhal Colitis | <input type="checkbox"/> Ulcerative Proctosigmoiditis |
| <input type="checkbox"/> Chronic Proctitis (rectum) | <input type="checkbox"/> Chronic Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Other: _____ |

(3) *Is the proposed insured taking any medications? If yes:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(4) *Has the proposed insured ever been hospitalized for the condition? If yes, please provide date(s):* _____

(5) *Has surgery been recommended? If yes, when will the surgery be completed?* _____

(6) *Has surgery been done? If yes, please list dates and type of surgery(ies):* _____

(7) *Has the proposed insured ever been disabled because of the condition? If yes, dates:* _____

(8) *Does the proposed insured have any other medical conditions that may affect underwriting? If yes, please provide details:*
