Phone: 888.227.3131
Fax: 215.233.3683

American Brokerage Services
The Career Company for Independent Agents

Inflammatory Bowel Disease Questionnaire

Agent: _____ ***Phone:*** _____ ***Fax:*** _____
Client: _____ ***DOB :*** _____ ***Male*** ***Female***
Product/Face Amount: _____ ***Height:*** _____ ***Weight:*** _____

- **TOBACCO/NICOTINE USE (*past or present*): YES*** NO**

****Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:*

- **Please provide details as to the diagnosis and frequency of symptom recurrence:**

Date of initial diagnosis: *Date of most recent episode:*
Total number of episodes or "flares" since diagnosis: *Number of episodes or 'flares" in past 6 months:* *Number of episodes or "flares" in past 2 years:*
Longest duration of symptoms (quantify in days, weeks, months): *Average duration (quantify in days, weeks, months):*

- **What specific condition(s) and/or symptoms have you been diagnosed with?** (*Check all that apply*)

Irritable bowl syndrome
Colon spasms
Frequent diarrhea
Acute Proctitis
Chronic Proctitis
Ulcerative Colitis
Crohn's Disease
Other:

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

- **Has surgery been preformed or recommended? If yes, when was the surgery completed/ planned?**

- **MEDICATIONS -** *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		***5.***	
2.		***6.***	
3.		***7.***	
4.		***8.***	

What, if any, medications are taken specifically during flare-ups of symptoms, but not routinely taken:

FAMILY HISTORY: (*Family history may be a factor in determining rate class*) **Is there a family history (*parent or siblings*) of the following conditions/disease onset prior to age 60:**

Cardiac Disease	**YES**	**NO**	***Diabetes***	**YES**	**NO**
Stroke or TIA	**YES**	**NO**	***Cancer***	**YES**	**NO**

Please provide details for any* "YES" *response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (*if living*)	DECEASED (*list age @ time of death*)
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

Do you have any other significant health issues or medical conditions not outlined or mentioned on this form? (*Complete additional questionnaires, as indicated*)

Condition(s) - List treatment and current status:

NONE - ***NO other medical conditions or health issues.***

Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.

Are there *<u>any</u>* other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?