Addison's Disease Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	**Date of first Diagnosis**		
2	**Has your client ever been hospitalized for Addison's Disease or Secondary Adrenal Insufficiency?**	☐ Yes ☐ No	*If yes, give details, dates and lengths of stay*
3	**List current medications (accurate name, dosage and reason)**		
4	**Has your client been prescribed steroids for any other illness?**	☐ Yes ☐ No	*If yes provide details:*
5	**Does the client have any other health issues**	☐ Yes ☐ No	*If yes provide details:*