

Adrenal Insufficiency 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, give details, dates and lengths of stay</i>		
3	List current medications (accurate name, dosage and reason)				
4	Has your client been prescribed steroids for any other illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes provide details:</i>		
5	Does the client have any other health issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes provide details:</i>		