Cerebral Palsy 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	At what age was Cerebral Palsy first diagnosed?	
2	Is client disabled?	☐ Yes ☐ No
	If disable, describe extent of disability:	
3	List current medications (accurate name, dosage and reason)	
4	Does the client have any other health issues	☐ Yes ☐ No
	If yes provide details	