Multiple Sclerosis Questionnaire

Name DOB Gender

Desired face amount and type of coverage:	
Height and Weight:	
Date of or Age at Diagnosis:	
Please indicate the number of episodes and date of last episode:	
Please list current neurologic status and/or symptoms:	☐ Normal ☐ Minimal Residual Impairment (specify): ☐ Moderate residual impairment (specify): ☐ Severe residual impairment (specify):
Date of last MRI brain scan and result: (MRI records will be required by UW)	
Medications being taken (provide dosage and frequency):	
Please describe tobacco use, including cigarettes, cigars, pipe, e-cigs and nicotine gum/patch:	
Have you ever had any other major medical conditions? Provide diagnosis date, treatment, results, etc.	
Other information:	

Please return the completed form to your financial professional.

All quotes are tentative and are NOT BINDING and SUBJECT TO full underwriting which may include exams, labs, doctor records, and/or any other information obtained during the underwriting process.