

Down's Syndrome Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M F Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30 ___UL

1. Does the proposed insured suffer from or have a history of any of the following:
(check all that apply):

___Heart disease or defect

___Digestive system problems

___Eye problems

___Alzheimer's disease

___Childhood leukemia

2. Is the proposed insured taking any medication? If so, please provide name, dosage and frequency:

3. Is the proposed insured disabled as a result of this condition? ___Yes ___No

4. Does the proposed insured live independently? ___Yes ___No