



Lyme Disease Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/ F

Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30

___UL

1. When was the proposed insured diagnosed with Lyme's Disease?

2. Does the proposed insured experience any of the following symptoms? (Check all that apply)

___Fatigue

___Fever and chills

___Muscle and Joint Pain

___Headache and stiff neck

___Swollen lymph nodes

___Other (please explain)

3. Are the skin, joints, nervous system and/or heart affected by Lyme disease? ___Yes ___No

Details: _____

4. Does, the proposed insured, have any other health conditions for which they receive ongoing

Treatment? _____

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

(If yes, please provide the date(s) of disability and monthly disability income)

6. Is the proposed insured taking any medication? ___Yes ___No

(If yes, please provide name, dosage, and frequency)
