

Underwriting Questionnaire

Colitis and Crohn's Disease



Producer Name _____ Phone _____ Date _____

Client Name _____ Date of Birth _____

Male Female Face Amount _____ Max Premium \$ _____ /yr.

Term Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)? Yes No

Frequency _____ Date of last use _____ Type _____

Exact diagnosis Colitis Crohn's Disease

Date of first diagnosis _____ Date of most recent episode _____ Total number of episodes _____

Number of episodes in past 6 months _____ Longest duration _____ (days, weeks, months)

Number of episodes in past 5 years _____ Longest duration _____ (days, weeks, months)

What conditions have been diagnosed

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Frequent colon spasms | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Ulcerative proctitis |
| <input type="checkbox"/> Mucous colitis | <input type="checkbox"/> Spastic colitis | <input type="checkbox"/> Catarrhal colitis | <input type="checkbox"/> Ulcerative proctosigmoiditis |
| <input type="checkbox"/> Chronic proctitis (rectum) | <input type="checkbox"/> Chronic ulcerative colitis | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Ischemic colitis |
| <input type="checkbox"/> Other _____ | | | |

Is the diagnosis considered Mild Moderate Severe

Date of last Colonoscopy _____ Result _____

Date of last Sigmoidoscopy _____ Result _____

Any significant effect on day-to-day functionality or any time lost from work as a result of the condition Yes No If yes, provide details

Any complications? If yes, please provide details below:

Has the client ever been hospitalized for the condition Yes No If yes, provide date(s) _____

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: