

# TIC Financial Services

## NERVOUS DISORDERS/DEMENTIA QUESTIONNAIRE

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Proposed Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Tobacco Use:  Yes  No Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. In. Weight: \_\_\_\_\_  
Broker's Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Proposed Insured please answer the following:

1. What is your actual diagnosis?
2. When were you diagnosed?
3. What were your first symptoms?
4. Please indicate dates and tests that have been completed to give you this diagnosis?

Date: \_\_\_\_\_ Test: \_\_\_\_\_

Results: \_\_\_\_\_

Date: \_\_\_\_\_ Test: \_\_\_\_\_

Results: \_\_\_\_\_

Date: \_\_\_\_\_ Test: \_\_\_\_\_

Results: \_\_\_\_\_

Date: \_\_\_\_\_ Test: \_\_\_\_\_

Results: \_\_\_\_\_

5. Is the disease mild and slowly progressive?  No  Yes, Details: \_\_\_\_\_

6. Has there been any deterioration in your memory?  No  Yes, Details: \_\_\_\_\_

7. Do you have any other major health problems?  No  Yes, Details: \_\_\_\_\_

8. Check all of the following that are applicable. I am able to:

Care for myself

Handle my own finances

Live on my own

Handle my own legal affairs

9. Are you on any medication(s)?  No  Yes, Name(s) and dosage(s): \_\_\_\_\_

10. Date you last consulted your physician: \_\_\_\_\_

11. Name and address of your physician(s): \_\_\_\_\_

12. Were the above questions answered by you, the proposed insured?  Yes  No

Who did? \_\_\_\_\_

Relationship: \_\_\_\_\_

Why? \_\_\_\_\_

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Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_