**AGENTS INSURANCE SERVICES of AMERICA, Inc.**
**Email: to UndSolutions@cs.com or Fax to: (760) 435 9703**
**Telephone: (760) 435 9702**

# Multiple Sclerosis (MS) Questionnaire

Name [] Male [] Female Age Date of Birth

Tobacco Use [] No []Cigarettes []Other tobacco Date quit?

State Amount of Insurance Type of Insurance

Occupation/Source of income:

1. Date Multiple Sclerosis diagnosed? Age at diagnosis?

2. Number of episodes? Date of last episode?

3. Current functional stage of Multiple Sclerosis?

[] No symptoms or residual

[] Mild symptoms or residual – Please describe:

[] Moderate symptoms or residual – Please describe:

[] Severe symptoms or residual – [] restricted to wheelchair or □ bed

4. Has the MS symptoms been progressing? [] No [] Yes

5. Current medications and treatments for MS:

**General Questions**:

1. Do you have any other major health problems? [] No [] Yes – Details:

2. List all medications:

3. Height Weight Most recent blood pressure reading:

**Agent Name**:

**Address:** **City:** **State:** **Zip:**

**Phone:** **Fax:** **Email:**

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance 