

MEDICAL HISTORY QUESTIONNAIRE: ULCERATIVE COLITIS

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

Never

Former Date Stopped: _____

Current Type: _____

Coverage Information:

Type: Term UL IUL

WL VUL Survivorship

Face Amount: _____

Premium Tolerance: _____

PROPOSED INSURED'S EXISTING INSURANCE

INSURANCE COMPANY	FACE AMOUNT	YEAR ISSUED	REPLACEMENT (YES/NO)

1. Date of diagnosis: _____

2. How often does your client visit his/her physician? _____

3. Date of last visit: _____

4. Type of Inflammatory Bowel Disease:

Chronic Ulcerative Colitis _____

Chronic Proctitis (inflammation in rectum only) _____

5. Please check if your client has (had) any of the following:

Hospitalizations for this disorder (list dates): _____

Surgery for this disorder (list dates): _____

Colonoscopy (date of most recent): _____



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6. Please list current medications:

NAME OF MEDICATION	DOSAGE	REASON

7. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____



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