

# Underwriting Questionnaire

## Autism

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 \_\_\_\_\_

Date of diagnosis \_\_\_\_\_ Does the client live independently  Yes  No Currently working  Yes  No

Select the option that best describes the autism

- Asperger's syndrome/High functioning (IQ above 70, None or very minimal impairment in sensorimotor ability, well developed language skills)
- Mild (IQ 50-70, minimal impairment in sensorimotor ability, ability to acquire grade school academic skills, vocational skills for self-support may be achieved, may need assistance or guidance if stressed but may also be able to live independently or with limited supervision)
- Moderate (IQ 35-49, able to acquire some communication skills with training, academic skills limited to early grade school level, social skills significantly impaired but may be able to perform unskilled or semi-skilled labor under supervision)
- Severe (Poor motor development, minimal speech and little or no communication skills, not able to live independently)
- Profound (IQ < 20, none to minimal speech and communication skills, need to live in a closely supervised environment)

History of seizures  Yes  No If yes, please provide the following:

Type of seizure  Grand mal  Petit mal  Partial seizure-complex  Focal

Symptoms experienced with seizures (select all that apply)

- Unconsciousness
- Clouded consciousness
- Uncontrolled twitching
- Deep sleep
- Other (provide details) \_\_\_\_\_

Frequency of seizures \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Any associated mental health or behavioral disorder (e.g. obsessive compulsive disorder, anxiety, panic attacks, depression or other) If yes, provide details \_\_\_\_\_

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

List any other major health problems the client has: