

THE PRODUCERS FIRM

P. O. Box 879
Bristol, CT 06011

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Fax: (860) 584-8462
www.jegoss.com

Agent's Name _____
Agent's Address & Telephone Number _____
Name of Proposed Insured _____
Date of Birth _____
State of Residence _____
Height _____ Weight _____
Smoker () Nonsmoker ()
Male () Female ()
Amount of Coverage _____
Product Type _____

Note: If proposed insured is applying for disability, please provide occupation, job description and income. If proposed insured is applying for term insurance, please state the level of term insurance (5, 10, 15, 20, 30).

MIASTHENIA GRAVIS RELATED UNDERWRITING QUESTIONS
(weakening of the muscles)

- 1. Date of diagnosis?
- 2. Is the condition well controlled?
- 3. What type of medication is he/she taking? How much and how often?
- 4. Are there any recurring respiratory problems?
- 5. Proposed Insureds' exercise habits?

FAMILY HISTORY

AGE IF LIVING STATE OF HEALTH
OR CAUSE OF DEATH AGE AT DEATH

Father _____
Mother _____
Brothers & _____
Sisters _____