

**The Brokerage Resource, Inc.**  
**IMMUNODEFICIENCY 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. Have you ever had any blood transfusions?  No  Yes, Date: \_\_\_\_\_  
Details: \_\_\_\_\_
  6. Have you ever tested positive for HIV?  No  Yes, Date: \_\_\_\_\_
  7. What symptoms did you have that caused you to be tested?
  8. Have you ever been told you have or had a STD, AIDS or AIDS related condition(s)?  
 No  Yes, Details \_\_\_\_\_
  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): \_\_\_\_\_
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Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_