

IMMUNODEFICIENCY QUESTIONNAIRE

Rohrer & Associates

Insured's Name: _____ DOB: _____ State: _____ Sex: M / F
Height: Ft. In. Weight: _____ Face Amount: _____
Tobacco use in the past 5 years: No Yes Details: _____
Producer: _____ State: _____ Phone: _____ E-mail: _____

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): _____

Additional Information: _____

Date: _____ Insured's Signature: _____