

# DOWN SYNDROME / RETARDATION

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. What is applicant's IQ? \_\_\_\_\_

2. Is applicant self-supporting?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

3. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

## DOWN SYNDROME

1. What is applicant's social and economic situation?

\_\_\_\_\_

\_\_\_\_\_

2. Are there any cardiovascular or pulmonary problems?  No  Yes; please give details

\_\_\_\_\_

\_\_\_\_\_

## RETARDATION

1. At what age did applicant become mentally retarded? \_\_\_\_\_

2. Is the retardation chromosomal?  No  Yes; PLEASE PROVIDE AS MUCH DETAIL AS POSSIBLE

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