



Diversified Marketing Group, Inc.
IMMUNODEFICIENCY QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
 Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
 Broker's Name: _____ Face Amount: _____
 BGA: _____ Phone: _____ Fax: _____

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): _____

Underwriter's Notes:

Date: _____ Proposed Insured's Signature: _____