Questionnaire:
Mental Nervous Health Prequalification

Berkshire Advisor Resource, Inc.

Please complete the following questions with as many details as possible:

Name of Proposed Insured: _____

1. Describe your symptoms occurring within the last 10 years, and reasons for your consultations or use of medications:

_____

_____

2. Date of first appointment/consultation: _____ Date of last appointment/Consultation: _____

3. Specific diagnosis: _____ Date diagnosed: _____

4. Name, address and phone number of physician or therapist: _____

_____

5. Describe type or treatment: _____

_____

6. Has treatment included the use of prescription medications? ☐ Yes ☐ No If yes, list medications including first and last dates each medication was taken and dosages (indicate any change in dosages):

_____

7. Name and address of prescribing physician, if other than as named in Item 4 above: _____

_____

Have you missed work for more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No

If yes, give dates and details: _____

9. Have you been an in-patient for any of the above conditions? ☐ Yes ☐ No If yes, give dates, reasons including name and address of hospital or facility: _____

_____

Use the space below for any additional information which may be helpful for the underwriting of you application:

_____

_____

_____

Signature of Proposed Insured: _____Date: _____

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