THE PRODUCERS FIRM
P. O. Box 879
Bristol, CT 06011

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Agent's Name ____
Agent's Address & Telephone Number_______________________________
Name of Proposed Insured ____
Date of Birth ________________________
State of Residence ____________________________
Height _________Weight _
Smoker ( ) Nonsmoker ( )
Male ( ) Female ( )
Amount of Coverage __________________
Product Type ________________________
Note: If proposed insured is applying for disability, please provide occupation, job description and income. If proposed insured is applying for term insurance, please state the level of term insurance (5, 10, 15, 20, 30).

MIASTHENIA GRAVIS RELATED UNDERWRITING QUESTIONS
(weakening of the muscles)

1. Date of diagnosis?
2. Is the condition well controlled?
3. What type of medication is he/she taking? How much and how often?
4. Are there any recurring respiratory problems?
5. Proposed Insureds' exercise habits?

FAMILY HISTORY

	AGE IF LIVING	STATE OF HEALTH OR CAUSE OF DEATH	AGE AT DEATH
Father			
Mother			
Brothers & Sisters			