APPLICATION NUMBER

INFANT QUESTIONNAIRE
AMERICAN INCOME LIFE INSURANCE COMPANY
PO BOX 2608
WACO, TX 76797

PLEASE INDICATE APPROPRIATE APPLICANT'S NAME IN SHADED AREA

NAME _____

1. Name of child: _____ Date of birth: _____

   Birth weight: _____ Birth length: _____

2. Was birth premature? ☐ Yes ☐ No If YES, by how much? _____

3. Were there any birth defects or medical problems? ☐ Yes ☐ No

   If YES, give details: _____

4. What is the child's current weight? _____ Current length? _____

5. Are there any current medical problems? ☐ Yes ☐ No

   If YES, give details: _____

6. Name, address and phone number of hospital where child was born: _____

   _____

   Date of discharge from hospital after birth: _____

   If kept longer than 3 days, and child had no birth defects or medical problems, reason for extended hospitalization: _____

   _____

7. Was the child discharged with an Apnea Monitor, or any other type of monitor? ☐ Yes ☐ No

   If YES, is monitor currently being used? ☐ Yes ☐ No

   If not currently using monitor, date discontinued: _____

8. Has the child been hospitalized since discharged at birth? ☐ Yes ☐ No

   Date _____ Reason _____ Duration _____

   Date _____ Reason _____ Duration _____

9. Is the child currently taking medication or have they ever taken medication on a long-term basis? ☐ Yes ☐ No

   Medications _____ Dosage _____ Frequency _____ Duration _____

   Medications _____ Dosage _____ Frequency _____ Duration _____

   Medications _____ Dosage _____ Frequency _____ Duration _____

   Name, address and phone number of prescribing physician: _____

   _____

10. Name, address and phone number of physician with current records: _____

    _____

X _____ _____ X _____ _____

Signature of Applicant Date Signature of Agent Date