© QUICK QUOTE FOR SARCOIDOSIS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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CLIENT: NAME ______________________ / [ ] M [ ] F / DOB ________ AGE ______ / HT ______ WT _____ / STATE ________

AMNT. REQUESTED $ ____________ / MAX. ANNUAL PREMIUM $ ____________ / TYPE OF INS.: [ ] PERM [ ] TERM YRS. LEVEL ________

TOBACCO USE: [ ] NO [ ] YES, DETAIL ________________ / REPLACEMENT? [ ] YES [ ] NO / CURRENT ANN. PREMIUM $ ___________

LAST LIFE INSURANCE APP.: YEAR ______ COMPANY ____________________ ACTION ______________________________

AGENT: NAME ______________________________________ PHONE ____________________ FAX ____________________

ADDRESS ____ CITY ____________________ ST _____ ZIP ____________

FOR USE BY CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION ____________________________________ FAX ____________________

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1. PLEASE LIST DATE OF FIRST DIAGNOSIS __________________

2. WAS A BIOPSY DONE?

[ ] YES [ ] NO

3. PLEASE NOTE STAGE DIAGNOSED ______________________

4. HOW WAS THE SARCOID TREATED?

[ ] PREDNISONE
[ ] NO TREATMENT

DATE TREATMENT WAS COMPLETED ______________________

5. IS THE CLIENT ON ANY MEDICATIONS FOR THIS IMPAIRMENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL __________________

____

6. PLEASE NOTE WHICH ORGANS WERE INVOLVED (CHECK ALL THAT APPLY):

[ ] LUNG
[ ] HEART
[ ] LIVER
[ ] SPLEEN
[ ] EYES
[ ] KIDNEY
[ ] CENTRAL NERVOUS SYSTEM
[ ] SKIN
[ ] LYMPH NODES

7. PLEASE GIVE RESULTS OF THE MOST RECENT PULMONARY FUNCTION TEST:

FVC ________________ FEV1 ______________________

8. HAS THERE BEEN ANY EVIDENCE OF RECURRENCE/PROGRESSION?

[ ] YES [ ] NO IF YES, PLEASE DETAIL ________________

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9. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL ________________

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10. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] YES [ ] NO IF YES, PLEASE DETAIL ________________

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11. CLIENT'S OCCUPATION __________________________

12. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

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