

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

**FAMILY HISTORY**

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
*If yes, use separate sheet to provide this information, including age of onset and date of death.*

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

- Date of first diagnosis: \_\_\_\_\_
- Was a biopsy done?  No  Yes
- Stage: \_\_\_\_\_
- How was the sarcoid treated?  No treatment  Prednisone
- Date treatment was completed: \_\_\_\_\_
- What organs were involved? (check all that apply)
  - Lung  Kidney  Heart  Central nervous system
  - Liver or spleen  Skin  Eyes  Lymph nodes
- Give results of the most recent pulmonary function tests:
 

FVC \_\_\_\_\_

FEV1 \_\_\_\_\_
- Has there been any evidence of recurrence/progression?  No  Yes; please give details

9. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

- Are there any other health problems? (additional questionnaires may be required)  No  Yes; please give details