

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 Disability **Coverage Amount:** _____
Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____
Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by 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: _____

6. What organs were involved? (check all that apply)
- Lung Kidney Heart Central nervous system
 Liver or spleen Skin Eyes Lymph nodes

8. Give results of the most recent pulmonary function tests:

FVC _____

FEV1 _____

9. Has there been any evidence of recurrence/progression? No Yes; please give details
- _____
- _____

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

(Accurate) Name of Medication	Dosage	Reason

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