SICKLE CELL ANEMIA

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?

1. Date of diagnosis: _____

2. What type of sickle cell anemia does client have?

☐ Sickle cell (SS)
☐ Sickle cell (SC)
☐ Sickle cell trait (SA)
☐ Hemoglobin C

3. Is there a history of complications? ☐ No ☐ Yes; please check those that apply and give the date of the last episode.

☐ Painful crisis Date: _____
☐ Aaseptic necrosis of bones Date: _____
☐ Leg ulcers Date: _____
☐ Lung scarring Date: _____
☐ Thrombosis Date: _____
☐ Enlarged heart Date: _____
☐ Other: _____ Date: _____

4. What is the current hemoglobin? _____

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

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

