

**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 UL

**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?

1. Date of first diagnosis: \_\_\_\_\_

2. Was a biopsy done?  No  Yes

3. Stage: \_\_\_\_\_

4. How was the sarcoid treated?  No treatment  Prednisone

5. 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