



INSURANCE MARKETING SERVICES

PRODUCTS SERVICE AND TECHNOLOGY

Sarcoidosis Questionnaire

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.

Agent's Name: _____ Phone #: _____

Proposed Insured: _____ Date of Birth: ___/___/___

Male () Female () Height _____ Weight _____ Smoker () Non Smoker ()

Amount of Coverage \$ _____ Product Type _____

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

Kidney

Heart

Central nervous system

Liver

Skin

Spleen

Lymph nodes

Eyes

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 _____

9. Has a parent, brother or sister died prior to age 65, other than by accident? [] Yes [] No

If yes, please detail _____

10. Does the client exercise three or more times per week? [] Yes [] No

If yes, please detail _____

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: _____
