Sarcoidosis Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

---

1. When was the proposed insured first diagnosed? _____

2. What stage of sarcoidosis has been diagnosed? ___ Stage 1 ___ Stage 2 ___ Stage 3

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

___ Fatigue	___ Loss of appetite or weight	___ Fever	___ Night Sweats
___ Skin rash	___ Enlarged lymph nodes	___ Blurred vision	___ Coughing
___ Chest pain	___ Joint stiffness or swelling	___ Wheezing	___ Irregular heartbeat

4. What organ systems are involved?

___ Lungs	___ Eyes	___ Skin	___ Lymph Nodes	___ Liver
___ Blood	___ Kidneys/Urinary Tract	___ Heart	___ Musculoskeletal	___ Nervous System

5. Has the proposed insured received any of the following treatments?

___ Prednisone Date: _____
___ Plaquenil Date: _____
___ Methotrexate Date: _____
___ Imuran Date: _____
___ Cytoxan Date: _____
___ Other: _____

6. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
If yes, provide name, dosage and frequency of medication(s) _____
_____

FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com