Wegener's Granulomatosis 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 with Wegener's Granulomatosis? _____

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

___ Upper respiratory symptoms ___ Joint Pains ___ Weakness
___ Skin Lesions ___ Fever ___ Night sweats
___ Conjunctivitis ___ Scleritis ___ Episcleritis
___ Other: _____

3. Have any of the following been affected by this condition?

___ Lungs ___ Kidneys ___ Musculoskeletal System ___ Eyes ___ Skin

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

___ Prednisone Details: _____
___ Cyclophosphamide Details: _____
___ Azathioprine Details: _____
___ Methotrexate Details: _____
___ Bactrim or Septra Details: _____
___ Leucovorin Details: _____
___ Other: _____

5. Is the proposed insured disabled as a result of this condition? ___ Yes ___ No
If yes, provide details: _____
_____

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