

**Agent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_ (M or F): \_\_\_\_\_ Age: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max Premium \$: \_\_\_\_\_ / year Type: (UL, WL, Term, or Survivorship) \_\_\_\_\_

Do you currently smoke cigarettes? (Y or N): \_\_\_\_\_ If no, did you ever smoke: (Y or N): \_\_\_\_\_ Quit date: \_\_\_\_\_

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: (Month) \_\_\_\_\_ (Year) \_\_\_\_\_ Type used last: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ What type of lupus has been diagnosed: Discoid or Systemic (disseminated) Lupus (SLE) \_\_\_\_\_

Which organs/tissues have been involved: (Y or N):

Skin: \_\_\_\_\_ Kidneys: \_\_\_\_\_ Central Nervous System: \_\_\_\_\_ Other: \_\_\_\_\_

Has the condition disappeared completely? (Y or N, If Yes, date of last required treatment:) \_\_\_\_\_

If the condition has ever disappeared, has it relapsed?

	Date Started:	Date Ended:
Initial Lupus Episode:	_____	_____
Condition's Most Recent Disappearance:	_____	_____
Condition's Most Recent Relapse:	_____	_____

What medications were/are being used to control the condition or any other condition affecting the proposed insured?

Name of Medication (Prescription or Otherwise):	Dates used:	Quantity Taken:	Frequency Taken:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any other medical information that may help provide a realistic preliminary assessment:

\_\_\_\_\_

\_\_\_\_\_

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