

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 first diagnosis: _____ How was the sarcoidosis diagnosed (e.g. by x-ray)? _____

Was the condition staged? If Y, please list stage: _____

Describe current symptoms, if any: _____

Was there (is there) any treatment for the condition? If Y, please describe: _____

_____ Date of last treatment: _____

Has there been any organ involvement? If Y, please list which ones: _____

Has there ever been a recurrence? If Y, please list approximate dates of any recurrent episodes: _____

Please provide the results of the most recent pulmonary function tests, if available:

FVC: _____ **FEV1:** _____

Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual?

Does the proposed insured take any medications or have been taken in the past?

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