SARCOIDOSIS QUESTIONNAIRE

Global Insurance Resources Group Inc.
9744 WILSHIRE BOULEVARD SUITE 306, Beverly Hills, CA 90212
PHONE (310) 550-3300 FAX (310) 550-3390

CLIENT: NAME _____ [ ] M [ ] F, DATE OF BIRTH _____

AGE_____ HT _____ WT_____ STATE _____

AMOUNT REQ. $_____ MAX. ANNUAL PREMIUM $_____

TYPE OF INSURANCE: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL_____

REPLACING? [ ] NO [ ] YES CURRENT ANN. PREM. $ _____

LAST LIFE INSURANCE APP. YEAR:_____ COMPANY_____
ACTION_____

AGENT: NAME_____ PHONE_____FAX_____

ADDRESS_____ CITY_____ ST_____ ZIP _____

---

1. PLEASE LIST THE 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?
[ ] NO [ ] YES, PLEASE DETAIL
_____

_____

6. PLEASE NOTE WHICH ORGANS WERE INVOLVED (CHECK ANY THAT APPLY)
[ ] LUNG
[ ] HEART
[ ] LIVER

9. CLIENT'S OCCUPATION _____

10. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?
[ ] NO [ ] YES, PLEASE DETAIL _____

_____

11. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?
[ ] NO [ ] YES, PLEASE DETAIL
_____

_____

12. PLEASE LIST ANY OTHER IMPAIRMENTS OR ILLNESSES; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:
_____

_____

_____

[ ] SPLEEN _____
[ ] EYES
[ ] KIDNEY
[ ] CENTRAL NERVOUS SYSTEM
[ ] SKIN
[ ] LYMPH NODES

7. PLEASE GIVE RESULTS OF THE MOST RECENT PULMONARY FUNCTION TEST:
PVC _____ FEV1_____

8. HAS THERE BEEN ANY EVIDENCE OF RECURRENCE
AND / OR PROGRESSION?
[ ] NO [ ] YES, PLEASE DETAIL
_____

_____