

# CPS QUICK QUOTE FOR SARCOIDOSIS

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. © COPYRIGHT CPS

**CLIENT:** NAME \_\_\_\_\_ /  M  F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS.  UL  TERM YRS. LVL \_\_\_\_\_

TOBACCO USE  NO  YES, TYPE \_\_\_\_\_ / REPLACEMENT  YES  NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK?  NO  YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ / DATE OF LAST EKG \_\_\_\_\_ AND RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (RESULTS) \_\_\_\_\_ / \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE  NO  YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) \_\_\_\_\_, \_\_\_\_\_ TREATED FOR CHOLESTEROL  NO  YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**CPS OFFICE ONLY:** ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. PLEASE LIST DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. WAS A BIOPSY DONE?  YES  NO

3. PLEASE LIST STAGE DIAGNOSED \_\_\_\_\_

4. HOW WAS THE SARCOID TREATED?

- PREDNISONE  
 NO TREATMENT  
 OTHER \_\_\_\_\_

DATE TREATMENT COMPLETED \_\_\_\_\_

5. IS THE CLIENT ON MEDICATIONS FOR THIS IMPAIRMENT?

NO  YES, DETAILS \_\_\_\_\_

6. PLEASE NOTE WHICH ORGANS WERE INVOLVED (CHECK ALL THAT APPLY):

- LUNG  
 HEART  
 LIVER  
 SPLEEN  
 EYES  
 KIDNEY  
 CENTRAL NERVOUS SYSTEM  
 SKIN  
 LYMPHNODES

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

FVC \_\_\_\_\_ FEV1 \_\_\_\_\_

8. HAS THERE BEEN ANY EVIDENCE OF RECURRENCE OR PROGRESSION?

NO  YES, DETAILS \_\_\_\_\_

8. LIST ANY OTHER ILLNESSES OR IMPAIREMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):

\_\_\_\_\_  
\_\_\_\_\_