

Brokerage Concepts, Inc.  
Quick Quote Form

Please fax completed form to:

(610)878-9614

to the attention of:

Life Brokerage Manager

# BROKERAGE CONCEPTS, INC. - QUICK QUOTE FOR SARCOIDOSIS

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE SUBJECT TO VERIFICATION OF THE SUBMITTED MEDICAL EVIDENCE AND OTHER CRITERIA USED IN THE UNDERWRITING OF LIFE INSURANCE.

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

AMNT. 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(S), AGE(S) AND CAUSE(S) \_\_\_\_\_

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 \_\_\_\_\_

LAI OFFICE ONLY: ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

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1. PLEASE LIST 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 \_\_\_\_\_

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

[ ] LUNG  
[ ] HEART  
[ ] LIVER  
[ ] SPLEEN  
[ ] EYES  
[ ] KIDNEY  
[ ] CENTRAL NERVOUS SYSTEM  
[ ] SKIN  
[ ] LYMPH NODES

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

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

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

[ ] NO [ ] YES, PLEASE DETAIL \_\_\_\_\_

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9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS, ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

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