

Fax to: Underwriting Solutions (760) 435-9703  
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## Leukemia Questionnaire

Name  Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Tobacco Use:  No  Cigarettes  Other tobacco \_\_\_\_\_ Date quit? \_\_\_\_\_

State \_\_\_\_\_ Amount of Insurance \_\_\_\_\_ Type of Insurance \_\_\_\_\_

Occupation/Source of income: \_\_\_\_\_

1. Type of Leukemia:  Acute  Chronic \_\_\_\_\_

Granulocytic  Lymphoblastic  Lymphocytic  Myelogenesis \_\_\_\_\_

Non-lymphoblastic  Erthroleukemia  Hairy Cell Lymphosacoma \_\_\_\_\_

Other \_\_\_\_\_

2. Date Leukemia was diagnosed: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_

3. Any Recurrence?  No  Yes- Details: \_\_\_\_\_

4. Treatments (check all that apply): \_\_\_\_\_

Close observation  Pentostatin  Splenectomy- Date: \_\_\_\_\_

Bone Marrow Transplant- Date: \_\_\_\_\_  Interferon  2-cdA \_\_\_\_\_

Other treatment – Details and dates: \_\_\_\_\_

5. Most recent CBC (complete blood count) results? \_\_\_\_\_

Date of last CBC test: \_\_\_\_\_  Hemoglobin: \_\_\_\_\_

White blood cell count: \_\_\_\_\_  Platelet count: \_\_\_\_\_

### General Questions:

1. Do you have any other major health problems?  No  Yes – Details: \_\_\_\_\_

2. List all medications: \_\_\_\_\_

3. Height: \_\_\_\_\_ Weight: Most recent blood pressure reading: \_\_\_\_\_

Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

The information gathered above will be used in the evaluation of the insurability of the applicant. All offers are tentative and are subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance Copyright 2000 to 2004.

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