



ULCERATIVE COLITIS (CROHN'S DISEASE) 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 NOTE TYPE OF INFLAMMATORY BOWEL DISEASE PRESENT:

- [] CHRONIC ULCERATIVE COLITIS
- [] CHRONIC PROCTITIS
- [] CROHN'S DISEASE

2. PLEASE LIST DATE OF ONSET _____

3. PLEASE NOTE SEVERITY:

- [] **MILD** (UP TO 4 WEEKS DURATION, MAXIMUM 1 ATTACK PER WEEK?)
- [] **MODERATE** (4 TO 6 WEEKS DURATION, 2 ATTACKS PER YEAR)
- [] **SEVERE** (OVER 6 WEEKS DURATION, 3 OR MORE ATTACKS PER YEAR)

4. PLEASE NOTE LOCATION (S) OF ULCERATIVE COLITIS:

- [] LARGE COLON
- [] SMALL BOWEL
- [] RECTUM ONLY (PROCTITIS)

5. PLEASE DETAIL TREATMENT INVOLVED (CHECK AND DETAIL FOR ALL THAT APPLY):

[] MEDICATION, TYPE AND DOSAGE _____

7. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

- [] NO [] YES, PLEASE DETAIL

8. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

- [] NO [] YES, PLEASE DETAIL

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

SURGERY

RESECTION WITH TOTAL COLECTOMY,
DATE _____

RESECTION WITH PARTIAL
COLECTOMY, DATE _____

HOSPITALIZATION, DATES _____

**6. PLEASE NOTE OTHER RELATED
COMPLICATIONS OR IMPAIRMENTS
(CHECK ALL THAT APPLY):**

LIVER DISORDER OR RELEVATED
LIVER

FUNCTION TESTS

ANEMIA

GASTROINTESTINAL BLEEDING

TRANSFUSIONS

ARTHRITIS _____