

**Life Scan Questionnaire for COLITIS/CROHN'S**  
LIFE INSURANCE RISK EVALUATION AND MARKET SEARCH

For \_\_\_\_\_ [ ] Male [ ] Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ State \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ [ ] **Non Smoker** [ ] **Smoker**

Have you ever used tobacco? [ ] Yes [ ] No If yes, state month and year of last use of any tobacco product: \_\_\_\_\_

Type of tobacco used: [ ] Cigarettes [ ] Cigars [ ] Chews [ ] Pipe  
Amt\$ \_\_\_\_\_ Type: [ ] Whole Life or Universal [ ] Term

Last application for life insurance: Year \_\_\_\_\_ Company \_\_\_\_\_

Result: [ ] Preferred [ ] Standard [ ] Rated/Rating \_\_\_\_\_ [ ] Declined

1. Please note **type** of Inflammatory Bowel Disease Present:

[ ] **Chronic Ulcerative Colitis**

[ ] **Crohn's Disease**

2. Date of onset \_\_\_\_\_

3. Please note severity:

[ ] **Mild** (up to 4 weeks duration, maximum one attack per year)

[ ] **Moderate** (4 to 6 weeks duration, 2 attacks per year)

[ ] **Severe**

4. Note **location(s)** of **Ulcerative Colitis**

[ ] Large Colon

[ ] Small Bowel

5. Date if last attack or bout? \_\_\_\_\_

6. **Treatment.** (Answer all that apply)

**Medication**, type and dosage \_\_\_\_\_

[ ] Surgery, Type

Month \_\_\_\_\_ Year \_\_\_\_\_

[ ] Resection with total Colectomy Month \_\_\_\_\_ Year \_\_\_\_\_

[ ] Resection with partial Colectomy Month \_\_\_\_\_ Year \_\_\_\_\_

[ ] Last Hospitalization Month \_\_\_\_\_ Year \_\_\_\_\_

7. List any related complications, if any \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Life Factors**

**Date of last stress EKG**

Month \_\_\_\_ Year \_\_\_\_ [ ] Never

**Family History**, has either parent or any sibling died before age 65?

[ ] Yes [ ] No If yes, please list cause and age.

\_\_\_\_\_

**Blood Pressure**, with or without medication \_\_\_\_\_ / \_\_\_\_\_

List medication, if any

\_\_\_\_\_

Result of last **Cholesterol** test, if known \_\_\_\_\_

List all **Other Illnesses** not listed on this page.

\_\_\_\_\_

\_\_\_\_\_

List all medications currently being used except those previously listed.

(name, dosage and times per day)

\_\_\_\_\_

\_\_\_\_\_

**Agent Information**

Name \_\_\_\_\_

Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_

ST \_\_\_\_ Zip \_\_\_\_\_ email \_\_\_\_\_

Telephone \_\_\_\_\_

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This is not an application for life insurance. The information contained herein will be used solely for the purpose of assessing which insurance carriers are likely to respond most favorably to the risk situation as stated above. The questions and answers listed will be used in the evaluation of the person listed above. All quotes are tentative, and are subject to the submitted medical evidence and other criteria used in the underwriting of life insurance. **Copyright 1997 George Varanakis**