

## TIC Financial Services

### LUPUS and CONNECTIVE TISSUE QUESTIONNAIRE

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Proposed Insured's Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Amount:	Height: Ft.	In. Weight:
Broker's Name:	Face Amount:	
Address	Phone:	Fax:

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Proposed Insured please answer the following:

1. Indicate your actual diagnosis:

- |  |  |
|--|--|
| <input type="checkbox"/> Discoid Lupus | <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)              |
| <input type="checkbox"/> Sarcoidosis   | <input type="checkbox"/> Scleredema <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Other:        |  |

2. When did you first notice any symptoms?

3. Please indicate dates and tests that have been completed to give you this diagnosis?

Date: Test:

Results:

Date: Test:

Results:

Date: Test:

Results:

Date: Test:

Results:

4. Have you had any of the following conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Low blood counts               | <input type="checkbox"/> Proteinuria         | <input type="checkbox"/> Lung involvement (pleuritis)     |
| <input type="checkbox"/> Neurological disorder          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart involvement (pericarditis) |
| <input type="checkbox"/> Renal insufficiency or failure |  |   |

5. Have you been diagnosed with any anemia in the past or currently? ☐ No ☐ Yes, Details:

6. Have you gone into remission? ☐ No ☐ Yes, How long:

7. Are you under any treatment? ☐ No ☐ Yes, Details:

8. What treatment are you receiving currently or have you received in the past?

9. Are you on any medication(s)? ☐ No ☐ Yes, Name(s) and dosage(s):

10. Date you last consulted your physician:

11. Name and address of your physician(s):

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Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_