

Idiopathic Thrombocytopenic Purpura

CLIENT NAME: _____ Date: _____

Male Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: Never used Totally stopped Date stopped: _____ Use now Type of nicotine product: _____

Type of Coverage: Term UL Survivor Disability Coverage Amount: _____

Annual Income: _____ Occupation/Job duties: _____ State of Residence: _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: _____
2. Acute or chronic: _____
3. Cause known? ___ No ___ Yes- Details: _____
4. Details of prior treatment (including if there is a history of removal of the spleen):

5. Date of last treatment: _____
6. Last 3 platelet counts and dates obtained: _____

7. Any of the following complications:
 - a. Enlarged spleen: ___ No ___ Yes
 - b. Bleeding episodes: ___ No ___ Yes- Please include details including type of bleeding episode and date of last episode: _____

8. Any other blood count abnormalities? ___ No ___ Yes- Details: _____
9. Any other complications, medical problems, or medications not mentioned above?

