

# Crohn's Disease Quote Request

Name \_\_\_\_\_ Sex M F Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Smoker? Y N State \_\_\_\_\_

Coverage Desired? \_\_\_\_\_ Amount \_\_\_\_\_ Plan Desired? \_\_\_\_\_

Have you ever been Rated or Declined for insurance? If YES Complete details please

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Have you ever been diagnosed with: (Please circle those that apply) Y N

Crohn's Disease Regional Enteritis Ulcerative Colitis? Chronic Proctitis

Date of first diagnosis \_\_\_\_\_

Have you ever had any of the following: (Please circle those that apply)

Hospitalization(s) for this disorder (Dates please) \_\_\_\_\_

Surgery(s) for this disorder (Dates please) \_\_\_\_\_

Colonoscopy (Please list dates of most recent) \_\_\_\_\_

What have been your recent Blood Pressure readings? \_\_\_\_\_ Cholesterol \_\_\_\_\_

Do you have Diabetes? Y N When Diagnosed? \_\_\_\_\_

If YES, what medication are you taking? \_\_\_\_\_

Do you have any Family History of Heart Disease or Diabetes? \_\_\_\_\_

What Lifestyle Changes have you made to treat your illness? \_\_\_\_\_

Please list all medications being taken: \_\_\_\_\_

Do you have any other major health problems? (example: cancer, etc)? \_\_\_\_\_

*Please also submit a copy of any Pathology Report - We must have to quote properly.*

Broker Submitting Questionnaire: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ E-mail: \_\_\_\_\_

Please send completed form:

Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787  
You may Fax to: (631) 265-7054 or E-mail to: [vainc@victorson.com](mailto:vainc@victorson.com)