

Psoriatic Arthritis Questionnaire

Agent Name: _____ Phone #: _____ E-mail: _____
Client Name: _____ Date of Birth: _____ Sex: Male / Female
Height: _____ Weight: _____ State: _____ Smoker: Y / N Face Amount: _____
Type of Insurance: Universal Life Whole Life Survivorship Term (# of years)

1. When was the proposed insured first diagnosed with Psoriatic Arthritis? _____

2. Which type of psoriatic arthritis has been diagnosed?

Symmetric arthritis Asymmetric arthritis
 Distal interphalangeal predominant Spondylitis
 Arthritis mutilans

3. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

Pain, stiffness, swelling in joints
 Irritation and redness of the eye
 Red, scaly patches of the skin

4. How is the proposed insured being treated?

<input type="checkbox"/> Anti-inflammatory drugs	Details & Date: _____
<input type="checkbox"/> Disease-modifying antirheumatic drugs (Methotrexate, Neoral, Sandimmune)	Details & Date: _____
<input type="checkbox"/> Steroids	Details & Date: _____
<input type="checkbox"/> Biologic therapy (Enbrel)	Details & Date: _____
<input type="checkbox"/> Physical therapy	Details & Date: _____
<input type="checkbox"/> Assistive devices	Details & Date: _____
<input type="checkbox"/> Other: _____	

5. Is the proposed insured disabled as a result of this condition? Yes No

If yes, provide details: _____

6. Is the proposed insured current taking any medication(s)? Yes No

If yes, provide name, dosage and frequency of medication(s) _____

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