

## QUICK QUOTE FOR BUILD

**CLIENT:** NAME \_\_\_\_\_ /  M  F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS.  UL  TERM YRS. LVL \_\_\_\_\_

TOBACCO USE  NO  YES, TYPE \_\_\_\_\_ / REPLACEMENT  YES  NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

FAMILY HISTORY –  
 AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH \_\_\_\_\_

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK?  NO  YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ RESULTS \_\_\_\_\_

DATE OF LAST RESTING EKG \_\_\_\_\_ RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE?  NO  YES

LAST TOTAL CHOLESTEROL READING AND HDL READING \_\_\_\_\_ / ARE YOU TREATED FOR CHOLESTEROL?  NO  YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**CPS OFFICE ONLY:** ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. MEDICAL HISTORY DETAILS (CHECK ALL THAT APPLY):

HEART HISTORY / CONDITION  
 DIABETES HISTORY  
 HIGH BLOOD PRESSURE  
 CHOLESTEROL  
 SLEEP APNEA

2. PROVIDE THE FOLLOWING REGARDING BLOOD PRESSURE HISTORY:

CURRENT BP READING \_\_\_\_\_

HIGHEST BP READING \_\_\_\_\_

ANY TREATMENT? IF YES, DETAILS \_\_\_\_\_

3. PROVIDE THE FOLLOWING REGARDING CHOLESTEROL HISTORY:

CURRENT READING \_\_\_\_\_

HDL READING OR CHOL/HDL RATIO \_\_\_\_\_

HIGHEST CHOLESTEROL READING \_\_\_\_\_

ANY TREATMENT? IF YES, DETAILS \_\_\_\_\_

4. HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

WEIGHT LOSS IN LAST YEAR \_\_\_\_\_

LAST MEASURED BODY FAT % \_\_\_\_\_ / DATE \_\_\_\_\_

5. MEN ONLY: CHEST SIZE \_\_\_\_\_ IN. / WAIST SIZE \_\_\_\_\_ IN.

6. HAS A STANDARD MEDICAL CHECK-UP BEEN COMPLETED WITHIN THE PAST YEAR:

NO  YES, PLEASE PROVIDE:

DATE \_\_\_\_\_ RESULTS; \_\_\_\_\_

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):

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