CPS INSURANCE SERVICES

QUICK QUOTE FOR CORONARY BYPASS

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 _____

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1. DATE (S) OF BYPASS SURGERY (IES):

MONTH _____ YEAR _____
MONTH_____ YEAR _____

2. CLIENT'S AGE WHEN BYPASS WAS PERFORMED _____

3. HOW MANY GRAFTS WERE PERFORMED?
☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 OR MORE

4. INDICATE THE TYPE OF GRAFT(S) USED:

☐ SAPHENOUS VEIN (FROM LEGS)
☐ INTERNAL MAMMARY ARTERY
☐ BOTH

IF THERE WAS ANGIOPLASTY/STENT PLACEMENT DONE IN ADDITION TO BYPASS SURGERY, PLEASE CONTINUE WITH QUESTION #5, IF NOT, SKIP TO QUESTION #7

5. DATE OF CORONARY ANGIOPLASTY/STENT PLACEMENT

MONTH_____ YEAR_____

6. HOW MANY CORONARY ARTERIES WERE INVOLVED?

☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ 6 OR MORE

7. WHICH CONDITIONS PRECEDED THE BYPASS (PLEASE CHECK ALL THAT APPLY):

☐ HEART ATTACK
☐ CHEST PAIN
☐ IRREGULAR STRESS EKG
☐ EXTREME FATIGUE
☐ OTHER _____

8. DATE OF LAST:

☐CARDIAC FOLLOW-UP	DATE_____ RESULTS_____
☐RESTING EKG	DATE_____ RESULTS_____
☐STRESS TEST	DATE_____ RESULTS_____
☐NUCLEAR STRESS TEST	DATE_____ RESULTS_____
☐STRESS ECHO	DATE_____ RESULTS_____

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS TAKEN:

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