CPS INSURANCE SERVICES

QUICK QUOTE FOR MULTIPLE SCLEROSIS

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. PLEASE LIST DATE OF DIAGNOSIS ____________________

2. IS MULTIPLE SCLEROSIS ACTIVE: ☐ NO ☐YES

DATE OF LAST ATTACK _______________________________

3. PLEASE LIST CURRENT MEDICATION(S) TAKEN FOR MS AND DOSAGE(S) :

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4. WHAT IS THE DEGREE OF SEVERITY OF MS?

☐MILD – TOTAL OF 2 TO 4 MILD EXACERBATIONS WITH NO RESIDUALS

☐MODERATE – SLOWLY PROGRESSIVE, ONE OR TWO ATTACKS PER YEAR WITH RECOVERY BETWEEN ATTACKS, AND SOME MODERATE RESIDUALS SUCH AS CANE USE

☐SEVERE – PROGRESSIVE, MORE THAN 2 ATTACKS PER YEAR, WHEEL CHAIR CONFINEMENT, BEDRIDDEN

☐ RAPIDLY PROGRESSING SYMPTOMS

5. CURRENT SYMPTOMS (CHECK ALL THAT HAVE OCCURRED OVER THE PAST TWO YEARS):

☐ VISUAL DIFFICULTIES
☐ NUMBNESS
☐ WEAKNESS OR FATIGUE
☐ IMPAIRED SWALLOWING
☐ FREQUENT BLADDER INFECTIONS
☐ BOWEL CONTROL DIFFICULTIES
☐ USE OF CANE
☐ USE OF WHEEL CHAIR
☐ DIFFICULTY WITH SPEECH

6. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

☐ 0 TO 6 MONTHS AGO
☐ 6 TO 12 MONTHS AGO
☐ 12 TO 24 MONTHS AGO
☐ OVER 2 YEARS AGO

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

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