CPS INSURANCE SERVICES

QUICK QUOTE FOR OTHER ILLNESSES

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 ILLNESS(ES) AND DETAILS AND INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE AND/OR AMOUNT OF TREATMENT ON EACH:

TYPE/SEVERITY _______________________________________

DATE OF DIAGNOSIS: MONTH _______________ YEAR _______

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

☐ SURGERY ☐MEDICATION ☐OTHER:

____

TYPE/SEVERITY _______________________________________

DATE OF DIAGNOSIS: MONTH _______________ YEAR _______

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
☐ SURGERY ☐MEDICATION ☐OTHER:

____

TYPE/SEVERITY _______________________________________

DATE OF DIAGNOSIS: MONTH _______________ YEAR _______

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:
☐ SURGERY ☐MEDICATION ☐OTHER:

____

2. 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

3. 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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