

QUICK QUOTE FOR PARKINSON'S DISEASE

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. PLEASE LIST DATE OF INITIAL DIAGNOSIS _____
2. PLEASE NOTE THE CURRENT FUNCTIONAL STAGE:
 - STAGE 1– UNILATERAL INVOLVEMENT
 - STAGE 2– BILATERAL INVOLVEMENT, BUT NORMAL STANCE
 - STAGE 3– BILATERAL INVOLVEMENT WITH MILD POSTURAL IMBALANCE, BUT ABLE TO LEAD AN INDEPENDENT LIFE
 - STAGE 4– BILATERAL INVOLVEMENT WITH POSTURAL INSTABILITY, REQUIRES SUBSTANTIAL HELP
 - STAGE 5– SEVERE DISEASE, RESTRICTED TO BED OR WHEELCHAIR
3. PLEASE LIST CURRENT MEDICATIONS:

4. HAS THERE BEEN ANY EVIDENCE OF PROGRESSION?

 NO YES, DETAILS _____

5. PLEASE NOTE IF ANY OF THE FOLLOWING HAVE OCCURRED (PLEASE CHECK ALL THAT APPLY):
 - DEMENTIA
 - MEMORY PROBLEMS
 - ASPIRATION
 - RECURRENT INFECTIONS
 - FALLS
 - RECURRENT INJURIES

PLEASE PROVIDE DETAILS TO ANY CHECKED RESPONSES:

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

