CPS INSURANCE SERVICES

QUICK QUOTE FOR PULMONARY 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 _____

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1. PLEASE NOTE TYPE OF LUNG DISEASE:

☐ CHRONIC BRONCHITIS
☐ EMPHYSEMA
☐ RESTRICTIVE LUNG DISEASE
☐ ASTHMA

2. PLEASE PROVIDE DATE OF INITIAL DIAGNOSIS:

_____

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

☐ NO ☐YES, DATE _____

4. HAS THE CLIENT EVER SMOKED?

☐ YES, CURRENTLY SMOKES _____ (AMOUNT/DAY)

☐ YES, SMOKED IN THE PAST BUT QUIT _____ (DATE)

☐ NO, NEVER SMOKED

5. IS THE CLIENT ON ANY MEDICATION, AN INHALER OR OXYGEN TANK FOR THE DISEASE?

☐ NO ☐YES, DETAILS _____

_____

6. HAS THE CLIENT HAD A RECENT PULMONARY FUNCTION (BREATHING) TEST?

☐ NO ☐YES, RESULTS:

FVC: _____

FEV1: _____

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON A CHEST X-RAY OR CT SCAN?

☐ NO ☐YES, PROVIDE DETAILS AND DATES OF TESTING:

_____

_____

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

_____

_____

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