CPS INSURANCE SERVICES

QUICK QUOTE FOR RHEUMATOID ARTHRITIS

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 GIVE RELATION, AGE AND CAUSE, OF EACH _____
HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE; SPECIFY MEMBER AND ILLNESS PRIOR TO AGE 60. GIVE RELATION, AGE AND ILLNESS, OF EACH_____

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 _____ AND RESULTS _____

DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____/ ARE YOU TREATED FOR BLOOD PRESSURE □ NO □ YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____, _____ / TREATED FOR CHOLESTEROL □ NO □ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

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1. PLEASE LIST THE INITIAL DATE OF DIAGNOSIS _____

2. IS THE CLIENT ON ANY MEDICATIONS FOR THE DISEASE?

□ NO □ YES, PROVIDE NAME(S) & DOSAGE(S)_____

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3. HAS THE CLIENT EXPERIENCED ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

□ WEIGHT LOSS
□ FEVER
□ LOW BLOOD COUNTS
□ HEART DISEASE
□ LUNG DISEASE
□ LIVER ENZYME ABNORMALITY
□ KIDNEY DISEASE

PLEASE PROVIDE DETAILS REGARDING ALL CHECKED RESPONSES:

_____
_____
_____
_____
_____

4. PLEASE NOTE FUNCTIONAL ABILITY:

□ FULLY ACTIVE
□ SEDENTARY
□ USES WALKER, CANE, ETC.
□ USES WHEELCHAIR

PLEASE PROVIDE DETAILS IF USING WALKER, CANE OR WHEELCHAIR; NEED TO KNOW DATE OF INITIAL USE:

_____
_____
_____
_____

5. 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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