CPS INSURANCE SERVICES

QUICK QUOTE FOR STROKE (CVA) / MINI-STROKE (TIA)

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 SPECIFY IF CVA (STROKE) OR TIA (MINI-STROKE) :

____

2. PROVIDE DATE OF CLIENT'S FIRST STROKE OR TIA:
MONTH _________________________ YEAR ________________

3. PROVIDE DATE OF CLIENT'S LAST STROKE OR TIA:
MONTH _________________________ YEAR ________________

4. CAUSE OF STROKE OR TIA (IF KNOWN):
____

5. TYPE OF STROKE (IF KNOWN):
☐ ISCHEMIC
☐ HEMORRHAGIC
☐ LACUNAR INFARCT

6. PLEASE NOTE NUMBER OF STROKES OR TIA'S SUFFERED DURING THE PAST 24 MONTHS:
☐ NONE
☐ ONE
☐ TWO
☐ THREE

7. HAS CLIENT EVER HAD CAROTID ARTERY SURGERY AS THE RESULT OF A STROKE?

☐ NO ☐YES, DATE: MONTH _______________ YEAR ________

RESULTS ____

8. AS A RESULT OF THE STROKE, DOES CLIENT HAVE ANY RESIDUAL NEUROLOGICAL DEFICITS?

☐ NONE
☐ SLURRED SPEECH
☐ LOSS OF USE, OR RESTRICTED LIMB MOVEMENT
☐ OTHER IMPAIRMENT:

____

9. APPROXIMATE DATE OF THE LAST STRESS TEST:

☐ WITHIN THE LAST 6 MONTHS
☐ 6 MONTHS TO A YEAR AGO
☐ MORE THAN A YEAR AGO

RESULTS ____

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

____

____

____