

QUICK QUOTE FOR ULCERATIVE COLITIS & CROHN'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 NOTE TYPE OF INFLAMMATORY BOWEL DISEASE :

- CHRONIC ULCERATIVE COLITIS
- CHRONIC PROCTITIS
- CROHN'S DISEASE

2. PLEASE LIST DATE OF ONSET _____

3. PLEASE NOTE SEVERITY:

- MILD (UP TO 4 WEEKS DURATION, MAXIMUM 1 ATTACK PER YEAR)
- MODERATE (4 TO 6 WEEKS DURATION, 2 ATTACKSPER YEAR)
- SEVERE (OVER 6 WEEKS DURATION, 3 OR MORE ATTACKS PER YEAR)

4. PLEASE NOTE LOCATION(S) OF ULCERATIVE COLITIS:

- LARGE COLON
- SMALL BOWEL
- RECTUM ONLY (PROCTITIS)

5. DATE OF LAST ATTACK: _____

6. DATE OF LAST COLONOSCOPY AND RESULTS:

7. PLEASE DETAIL TREATMENT INVOLVED (CHECK AND DETAIL ALL THAT APPLY):

- MEDICATION, TYPE AND DOSAGE _____
- RESECTION WITH TOTAL COLECTOMY, DATE _____
- RESECTION WITH PARTIAL COLECTOMY, DATE _____
- SURGERY (IF OTHER), TYPE & DATE _____
- HOSPITALIZATION, DATE _____

8. PLEASE NOTE ALL OTHER RELATED COMPLICATIONS OR IMPAIRMENTS (CHECK ALL THAT APPLY):

- LIVER DISORDER OR ELEVATED LIVER FUNCTION TESTS; PROVIDE DETAILS BELOW IF CHECKED

AST _____ ALT _____ GGTP _____ ALK PHOS _____

- ANEMIA
- GASTROINTESTINAL BLEEDING
- TRANSFUSIONS
- ARTHRTIS

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