CPS INSURANCE SERVICES

# QUICK QUOTE FOR DEPRESSION

**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. PROVIDE DATE (S) OF DIAGNOSIS:
   ☐DEPRESSION _____
   ☐BIPOLAR DISORDER__ _____

2. REASON OR CAUSE OF DEPRESSION, IF KNOWN
   _____

3. HAS CLIENT EVER ATTEMPTED SUICIDE?
   ☐NO
   ☐YES, PLEASE PROVIDE:
   MONTH _____ YEAR _____
   MONTH _____ YEAR _____

4. HAS CLIENT EVER BEEN HOSPITALIZED FOR DEPRESSION?
   ☐NO ☐YES, PLEASE DETAIL:
   MONTH _____ YEAR _____
   MONTH _____ YEAR _____

5. DURING THE PAST 12 MONTHS, HAS THE CLIENT MISSED WORK DUE TO DEPRESSION?
   ☐NO ☐YES, PLEASE DETAIL NUMBER OF OCCASIONS AND TIME MISSED:
   _____

6. IS CLIENT CURRENTLY TAKING MEDICATION FOR DEPRESSION?
   ☐NO ☐YES, PLEASE PROVIDE NAME AND DOSAGE:

   _____

7. WHO IS CURRENTLY PRESCRIBING THE MEDICATION
   ☐CURRENT ATTENDING PHYSICIAN
   ☐PSYCHIATRIST/PSYCHOLOGIST
   ☐OTHER_____

8. IS CLIENT CURRENTLY SEEING OR HAS CLIENT SEEN A MENTAL HEALTH THERAPIST?
   ☐NO ☐NOT CURRENTLY ☐YES

   IF YES OR NOT CURRENTLY, PLEASE DETAIL HOW OFTEN, FOR HOW LONG, AND THE DATE OF THE LAST VISIT:
   _____

   _____

9. IS CLIENT CURRENTLY RECEIVING, OR IN THE PAST RECEIVED, DISABILITY BENEFITS DUE TO DEPRESSION OR OTHER DISABILITY?
   ☐NO ☐YES, PLEASE DETAIL START AND END DATES:
   START: MONTH _____ YEAR _____
   END: MONTH _____YEAR _____
   ☐YES, CLIENT IS STILL GETTING BENEFITS

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

    _____