CPS INSURANCE SERVICES

QUICK QUOTE FOR COGNITIVE DISORDERS/ MEMORY LOSS

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. HAVE YOU BEEN DIAGNOSED WITH:

   ☐ MEMORY LOSS
   ☐ MILD COGNITIVE DISORDER
   ☐ DEMENTIA
   ☐ ALZHEIMER'S
   ☐ OTHER; PLEASE SPECIFY_____

2. DATE DIAGNOSED_____

3. DESCRIBE THE SYMPTOMS THAT LED TO THIS DIAGNOSIS
_____
_____
_____
_____

4. SEVERITY OF DIAGNOSIS
   ☐ MILD ☐ MODERATE ☐ SEVERE

5. IF YOU HAVE NOT BEEN DIAGNOSED AS HAVING A COGNITIVE DISORDER, PLEASE DESCRIBE THE SYMPTOMS THATWARRANTED TESTING_____

DURATION OF SYMPTOMS _____

PRESENTCONDITION _____

6. HAS AN UNDERLYING CAUSE BEEN DETERMINED FOR THE COGNITIVE SYMPTOMS (PREVIOUS STROKE, ACCIDENT OR DISEASE):

IF YES, PLEASE SPECIFY _____

7. HAVE THE ACTIVITIES OF DAILY LIVING (BATHING, DRESSING, MOBILITY, ETC.) BEEN AFFECTED.
   ☐ YES
   ☐ NO
IF YES, PLEASE SPECIFY _____

8. TYPE OF COGNITIVE TESTING COMPLETED

NAME/TYPE OF TEST_____
DATE_____
RESULTS_____

9. LIST MEDICATIONS USED TO TREAT THE COGNITIVE DISORDER
_____
_____
_____

10. HAVE THE CONDITION OR SYMPTOMS PROGRESSED?
☐ YES; PLEASE SPECIFY _____
☐ NO

11. PURPOSE OF INSURANCE COVERAGE:
_____
_____

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