



QUICK QUOTE FOR SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. © COPYRIGHT CPS

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(S), AGE(S) AND CAUSE(S) _____

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 _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE ☐ NO ☐ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL ☐ NO ☐ YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. PLEASE LIST THE DATE OF FIRST DIAGNOSIS _____

2. PLEASE NOTE THE TYPE OF LUPUS DIAGNOSED:

- ☐ SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)
☐ DISCOID LUPUS
☐ DRUG INDUCED LUPUS

3. IS THE CLIENT ON ANY MEDICATIONS FOR THIS IMPAIRMENT?

☐ NO ☐ YES, PLEASE DETAIL TYPE AND DOSAGE _____

4. IS THE LUPUS IN REMISSION?

☐ YES ☐ NO, PLEASE LIST DATE OF LAST EXACERBATION _____

5. HAS THE CLIENT HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

- ☐ LOW BLOOD COUNTS
☐ LUNG INVOLVEMENT (PLEURITIS)
☐ PROTEINURIA
☐ HIGH BLOOD PRESSURE
☐ NEUROLOGIC DISORDER
☐ HEART INVOLVEMENT (PERICARDITIS)
☐ RENAL INSUFFICIENCY OR FAILURE

6. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

