



## QUICK QUOTE FOR CORONARY BYPASS

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) \_\_\_\_\_

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. WHEN WAS BYPASS SURGERY PERFORMED?

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

IF A SECOND BYPASS WAS PERFORMED:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

2. AGE WHEN BYPASS SURGERY WAS PERFORMED \_\_\_\_\_

3. HOW MANY GRAFTS WERE PERFORMED?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 OR MORE

4. INDICATE THE TYPE OF GRAFT(S) USED:

☐ SAPHENOUS VEIN (FROM LEGS)

☐ INTERNAL MAMMARY ARTERY

☐ BOTH

IF THERE WAS ANGIOPLASTY DONE IN ADDITION TO BYPASS SURGERY, PLEASE CONTINUE WITH QUESTION 5, IF NOT GO TO QUESTION 8.

5. WHEN WAS THE CORONARY ANGIOPLASTY PERFORMED?

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

IF A SECOND ANGIOPLASTY WAS PERFORMED:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

6. HOW MANY ARTERIES WAS THE PROCEDURE PERFORMED ON:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 OR MORE

7. WHICH CONDITIONS PRECEDED THE ANGIOPLASTY OR BYPASS?

☐ HEART ATTACK

☐ CHEST PAIN

☐ IRREGULAR STRESS EKG

☐ EXTREME FATIGUE

☐ OTHER \_\_\_\_\_

8. SINCE THE TIME OF THE ANGIOPLASTY OR BYPASS, HAS THE CLIENT EXPERIENCED EITHER OF THE FOLLOWING:

☐ CHEST PAIN

☐ IRREGULAR STRESS EKG

9. APPROXIMATE DATE OF THE LAST EKG:

☐ WITHIN THE LAST 6 MONTHS

☐ 6 MONTHS TO A YEAR AGO

☐ MORE THAN A YEAR AGO

10. 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_