COMPANIES • PRODUCTS • SERVICE

INSURANCE SERVICES SINCE 1974

QUICK QUOTE FOR OTHER ILLNESSES

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.

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 ILLNESS(ES) AND DETAILS (INCLUDE THE TYPE/SEVERITY, EXACT DATE OF DIAGNOSIS, TREATMENT AND DOSAGE OR AMOUNT OF TREATMENT, ON EACH):

TYPE/SEVERITY____________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

TYPE/SEVERITY____________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

TYPE/SEVERITY____________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

❑ SURGERY ❑ MEDICATION ❑ OTHER

____

____

2. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

❑ 0 TO 6 MONTHS AGO
❑ 6 TO 12 MONTHS AGO
❑ 12 TO 24 MONTHS AGO
❑ OVER 2 YEARS AGO

3. 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:

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