QUICK QUOTE FOR STROKE (CEREBROVASCULAR ACCIDENT)

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. THE DATE OF CLIENT'S FIRST STROKE:

MONTH _____ / YEAR _____

2. THE DATE OF CLIENT'S LAST STROKE:

MONTH _____ / YEAR _____

3. NUMBER OF STROKES SUFFERED DURING THE LAST 24 MONTHS:

❑ NONE
❑ ONE
❑ TWO
❑ THREE

4. HAS THE CLIENT EVER HAD CAROTID ARTERY SURGERY AS THE RESULT OF A STROKE?

❑ NO ❑ YES, PLEASE DETAIL:

MONTH _____ / YEAR _____

5. AS A RESULT OF STROKE, DOES THE CLIENT HAVE ANY RESIDUAL NEUROLOGICAL DEFICITS?

❑ NONE
❑ SLURRED SPEECH
❑ LOSS OF USE OR RESTRICTED LIMB MOVEMENT
❑ OTHER IMPAIRMENT _____

_____

_____

6. APPROXIMATE DATE OF THE LAST STRESS EKG:

❑ WITHIN THE LAST 6 MONTHS
❑ 6 MONTHS TO A YEAR AGO
❑ MORE THAN A YEAR AGO

7. 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:

_____

_____

_____