BB&G © QUICK QUOTE FOR CANCER

INFORMATION GATHERED WILL BE USED IN THE EVALUATION OF THE INSURABILITY OF THE APPLICANT. OFFERS ARE TENTATIVE AND ARE 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 _____

AMNT. REQUESTED $ _____ / MAX. ANNUAL PREMIUM $ _____ / TYPE OF INS.: [ ] PERM [ ] TERM YRS. LEVEL _____

TOBACCO USE: [ ] NO [ ] YES, DETAIL _____ / REPLACEMENT? [ ] YES [ ] NO / CURRENT ANN. PREMIUM $ _____

LAST LIFE INSURANCE APP.: YEAR _____ COMPANY _____ ACTION _____

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

FOR USE BY CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. TYPE OF MALIGNANCY OR CANCER?

[ ] BLADDER
[ ] BREAST
[ ] CERVICAL
[ ] COLON OR RECTAL (ALSO COMPLETE QUESTION #7)
[ ] HODGKIN'S DISEASE
[ ] MELANOMA* (ALSO COMPLETE QUESTION #8)
[ ] PROSTATE (ALSO COMPLETE QUESTION #9)
[ ] SKIN*
[ ] OTHER _____

*IF MELANOMA OR SKIN CANCER, PLEASE DETAIL:

TYPE _____

LOCATION ON BODY _____

2. HAS TUMOR OR MALIGNANCY METASTASIZED?
[ ] YES [ ] NO, PLEASE DETAIL:

DATE DIAGNOSED: MONTH _____ YEAR _____

3. STAGE OF TUMOR OR MALIGNANCY:

T ___ N ___ M ___ OR
[ ] 1 [ ] 2 [ ] 2A [ ] 2B [ ] 3 [ ] 3A [ ] 3B [ ] 4 [ ] 5

[ ] OTHER _____

4. TYPES OF TREATMENT USED (CHECK ALL APPLICABLE):

[ ] SURGICAL REMOVAL OF MALIGNANCY
[ ] CHEMOTHERAPY
[ ] RADIATION THERAPY
[ ] HORMONAL (ORCHIDECTOMY - DES. LUPRON)
[ ] OTHER _____

5. DATE OF LAST TREATMENT RECEIVED:

MONTH _____ YEAR _____

6. HAS THERE BEEN ANY MEDICAL EVIDENCE OF RECURRENT CANCER?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL:

MONTH _____ YEAR _____

7. DUKE'S SCALE (FOR COLON OR RECTAL CANCER ONLY):

[ ] A1 [ ] B1 [ ] B2 [ ] C1 [ ] C2 [ ] D

8. CLARK'S LEVEL (FOR MELANOMA ONLY):

[ ] I [ ] II [ ] III [ ] IV [ ] V

DEPTH OF MELANOMA _____

9. (FOR PROSTATE CANCER ONLY):

STAGE:

T ___ N ___ M ___
OR [ ] A1 [ ] A2 [ ] B1 [ ] B2 [ ] C1 [ ] C2 [ ] D

GLEASON'S GRADE: [ ] 2 OR 3 [ ] 4 OR 5 [ ] 6 OR MORE

RESULTS OF MOST RECENT PSA TEST _____

10. HAS A PARENT, BROTHER OR SISTER DIED PRIOR TO AGE 65, OTHER THAN BY ACCIDENT?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

_____

_____

11. DOES THE CLIENT EXERCISE THREE OR MORE TIMES PER WEEK?

[ ] YES [ ] NO IF YES, PLEASE DETAIL _____

12. CLIENT'S OCCUPATION _____

13. PLEASE LIST ANY OTHER ILLNESSES OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

_____

_____

_____

_____

_____