BB&G © QUICK QUOTE FOR PARALYSIS AND SPINAL CORD INJURY

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. WHAT CAUSED THE PARALYSIS?

[ ] TRAUMA, GIVE DETAILS AND DATE OF OCCURRENCE _____

_____

[ ] SURGERY, GIVE DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE

_____

_____

[ ] STROKE OR CEREBRAL VASCULAR ACCIDENT

[ ] OTHER DISEASE, PLEASE GIVE DETAILS _____

_____

2. PLEASE NOTE CURRENT LEVEL OF FUNCTION:

[ ] INCOMPLETE PARAPLEGIA
[ ] COMPLETE PARAPLEGIA
[ ] INCOMPLETE QUADRIPLEGIA
[ ] COMPLETE QUADRIPLEGIA

3. IF PARALYSIS FROM INJURY OR TRAUMA, AT WHAT SPINAL CORD LEVEL (LIST SPECIFIC VERTEBRAE IF AVAILABLE, I.E. C7-8)

[ ] CERVICAL SPINE _____

[ ] THORACIC SPINE _____

[ ] LUMBROSACRAL SPINE _____

4. HAVE ANY OF THE FOLLOWING OCCURRED (CHECK ALL THAT APPLY):

[ ] PNEUMONIA
[ ] SKIN ULCERS
[ ] URINARY TRACT INFECTION
[ ] KIDNEY IMPAIRMENT
[ ] DEPRESSION

5. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS (CHECK ALL THAT APPLY):

[ ] NORMAL BLADDER FUNCTION, OR [ ] NEEDS ASSISTANCE
[ ] NORMAL BOWEL FUNCTIONS, OR [ ] NEEDS ASSISTANCE
[ ] USES CANE ONLY
[ ] WHEEL CHAIR BOUND
[ ] BED BOUND
[ ] NEEDS ASSISTANCE EATING
[ ] NEEDS ASSISTANCE TO COMMUNICATE

6. IS TREATMENT CURRENTLY BEING PRESCRIBED?

[ ] YES [ ] NO IF YES, PLEASE DETAIL

_____

_____

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

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

_____

_____

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

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

_____

9. CLIENT'S OCCUPATION _____

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

_____

_____

_____

_____