© QUICK QUOTE FOR DEPRESSION

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.

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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 ________________

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1. CLIENT HAS BEEN DIAGNOSED AS:

[ ] HAVING DEPRESSION
[ ] BEING MANIC DEPRESSIVE (BIPOLAR)

2. HAS THE CLIENT EVER ATTEMPTED SUICIDE?

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

MONTH _________ YEAR _________

MONTH _________ YEAR _________

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR DEPRESSION?

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

MONTH _________ YEAR _________

MONTH _________ YEAR _________

4. DURING THE PAST 12 MONTHS, HAS THE CLIENT MISSED WORK DUE TO DEPRESSION?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL NUMBER OF OCCASIONS AND AMOUNT OF TIME MISSED:

____

____

5. IS THE CLIENT CURRENTLY TAKING MEDICATION FOR DEPRESSION?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL TYPE AND DOSAGE:

____

____

6. IS THE CLIENT CURRENTLY SEEING OR HAS HE/SHE SEEN A MENTAL HEALTH THERAPIST?

[ ] YES [ ] NOT CURRENTLY [ ] NO

IF YES, OR NOT CURRENTLY, PLEASE DETAIL HOW OFTEN, FOR HOW LONG, AND THE DATE OF THE LAST VISIT:

____

____

7. CLIENT'S MARITAL STATUS:

[ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED

8. CLIENT'S OCCUPATION __________________________

9. IS THE CLIENT CURRENTLY RECEIVING, OR IN THE PAST RECEIVED, DISABILITY BENEFITS DUE TO DEPRESSION OR OTHER DISABILITY?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL START AND END DATES:

START: MONTH _________ YEAR _________

END: MONTH _________ YEAR _________

[ ] IS STILL GETTING BENEFITS

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

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

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

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

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

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