BB&G © QUICK QUOTE FOR HEPATITIS (ELEVATED LIVER FUNCTIONS)

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. LIST DATE AND RESULTS OF THE CLIENT'S TWO MOST RECENT LIVER FUNCTION TESTS:

	RESULT	DATE#1	RESULT	DATE#2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. CHECK TYPE, THEN LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

[ ] A DATE _____ [ ] NEG [ ] POS

[ ] B DATE _____ [ ] NEG [ ] POS

[ ] C DATE _____ [ ] NEG [ ] POS

3. HAS THE CLIENT HAD A LIVER BIOPSY?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL DATE AND RESULTS:

_____

_____

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH:

FATTY LIVER? [ ] YES [ ] NO, IF YES, PLEASE DETAIL:

_____

HEPATITIS? [ ] YES [ ] NO, IF YES, CHECK TYPE, THEN DETAIL:

[ ] ACUTE [ ] CHRONIC ACTIVE [ ] CHRONIC PERSISTENT

DETAILS: _____

CIRRHOSIS? [ ] YES [ ] NO

5. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

[ ] YES [ ] NO, IF YES, PLEASE DETAIL FREQUENCY AND AMOUNT:

_____

IF NO, DATE OF LAST DRINK:

MONTH _____ YEAR _____

6. 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

7. LIST THE LAST CHOLESTEROL READING, IF KNOWN:

_____ HDL RATIO _____

8. LIST THE LAST BLOOD PRESSURE READING, IF KNOWN:

_____ SYSTOLIC/ _____ DIASTOLIC

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

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

_____

_____

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

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

_____

11. CLIENT'S OCCUPATION _____

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

_____

_____

_____