BB&G © QUICK QUOTE FOR MULTIPLE SCLEROSIS

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. DATE MULTIPLE SCLEROSIS WAS DIAGNOSED _____

2. IS MULTIPLE SCLEROSIS ACTIVE? _____ YES _____ NO

IF YES, WHAT IS THE DATE OF THE LAST ATTACK _____

3. WHAT IS THE DEGREE OF SEVERITY OF MULTIPLE SCLEROSIS?

[ ] MILD - TOTAL 2 TO 4, MILD EXACERBATIONS WITH NO RESIDUALS
[ ] MODERATE - SLOWLY PROGRESSIVE, ONE OR TWO ATTACKS PER YEAR WITH RECOVERY BETWEEN ATTACKS, SOME MODERATE RESIDUALS, SUCH AS CANE USE
[ ] SEVERE - PROGRESSIVE, MORE THAN 2 ATTACKS PER YEAR, WHEEL CHAIR CONFINEMENT, BEDRIDDEN
[ ] RAPIDLY PROGRESSING SYMPTOMS

4. CURRENT SYMPTOMS (CHECK ALL THAT HAVE OCCURRED OVER THE PAST TWO YEARS:

[ ] VISUAL DIFFICULTIES
[ ] NUMBNESS
[ ] WEAKNESS OR FATIGUE
[ ] IMPAIRED SWALLOWING
[ ] FREQUENT BLADDER INFECTIONS
[ ] BOWEL CONTROL DIFFICULTIES
[ ] USE OF CANE
[ ] USE OF WHEEL CHAIR
[ ] DIFFICULTY WITH SPEECH

5. 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

6. LIST THE LAST CHOLESTEROL READING, IF KNOWN:

_____ HDL RATIO _____

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

_____ SYSTOLIC/ _____ DIASTOLIC

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

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

_____

_____

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

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

_____

10. CLIENT'S OCCUPATION _____

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

_____

_____

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