© QUICK QUOTE FOR OTHER ILLNESSES

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. PLEASE LIST ILLNESS(ES) AND DETAILS (INCLUDE THE TYPE/SEVERITY, MONTH AND DATE OF DIAGNOSIS, TREATMENT AND DOSAGE OR AMOUNT OF TREATMENT, ON EACH):

TYPE/SEVERITY ____________________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

[ ] SURGERY [ ] MEDICATION [ ] OTHER

____

____

TYPE/SEVERITY ____________________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

[ ] SURGERY [ ] MEDICATION [ ] OTHER

____

____

TYPE/SEVERITY ____________________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

[ ] SURGERY [ ] MEDICATION [ ] OTHER

____

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TYPE/SEVERITY ____________________

DATE OF DIAGNOSIS: MONTH ________ YEAR ________

TYPE OF TREATMENT AND DOSAGE OR AMOUNT:

[ ] SURGERY [ ] MEDICATION [ ] OTHER

____

____

2. 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

3. LIST THE LAST CHOLESTEROL READING, IF KNOWN:

__________ HDL RATIO __________

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

________ SYSTOLIC/ ________ DIASTOLIC

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

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

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7. CLIENT'S OCCUPATION ____________________

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

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