© QUICK QUOTE FOR PARKINSON'S DISEASE

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. PLEASE LIST THE DATE OF THE FIRST DIAGNOSIS _____

2. PLEASE NOTE THE CURRENT FUNCTIONAL STAGE OF THE CLIENT:

[ ] STAGE 1 – UNILATERAL INVOLVEMENT

[ ] STAGE 2 – BILATERAL INVOLVEMENT, BUT NORMAL STANCE

[ ] STAGE 3 – BILATERAL INVOLVEMENT WITH MILD POSTURAL MBALANCE BUT ABLE TO LEAD AN INDEPENDENT LIFE

[ ] STAGE 4 – BILATERAL INVOLVEMENT WITH POSTURAL INSTABILITY, REQUIRES SUBSTANTIAL HELP

[ ] STAGE 5 - SEVERE DISEASE, RESTRICTED TO BED OR WHEELCHAIR

3. HAS THERE BEEN ANY EVIDENCE OF PROGRESSION?

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

_____

_____

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

[ ] DEMENTIA
[ ] MEMORY PROBLEMS
[ ] ASPIRATION
[ ] RECURRENT INFECTIONS
[ ] FALLS
[ ] RECURRENT INJURIES

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

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

_____

_____

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

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

_____

7. CLIENT'S OCCUPATION _____

8. 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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