© QUICK QUOTE FOR RHEUMATOID ARTHRITIS

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 THE DATE OF FIRST DIAGNOSIS ____________

2. IS THE CLIENT ON ANY MEDICATIONS FOR THE DISEASE?

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

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3. HAS YOUR CLIENT EXPERIENCED ANY OF THE FOLLOWING (PLEASE CHACK ALL THAT APPLY):

[ ] WEIGHT LOSS
[ ] FEVER
[ ] LOW BLOOD COUNTS
[ ] HEART DISEASE
[ ] LUNG DISEASE
[ ] LIVER ENZYME ABNORMALITY
[ ] KIDNEY DISEASE

4. PLEASE LIST FUNCTIONAL ABILITY:

[ ] FULLY ACTIVE
[ ] SEDENTARY
[ ] USES WALKER, CANE, ETC.
[ ] USES WHEELCHAIR

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 OR IMPAIRMENTS; ALONG WITH ANY AND ALL MEDICATIONS CURRENTLY BEING TAKEN, INCLUDE THE DOSAGE AND FREQUENCY OF EACH:

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