INSURANCE SERVICES SINCE 1974

COMPANIES • PRODUCTS • SERVICE

QUICK QUOTE FOR PULMONARY DISEASE

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance. © COPYRIGHT CPS

CLIENT: NAME ______________________ / ❑ M ❑ F / DOB __________ AGE ______ / HT ______ WT _____ / STATE ______

AMT. REQUESTED $ ________________ / MAX. ANNUAL PREMIUM $ _____________ / TYPE OF INS. ❑ UL ❑ TERM YRS. LVL _________

TOBACCO USE ❑ NO ❑ YES, TYPE _____________________ / REPLACEMENT? ❑ YES ❑ NO / CURRENT ANN. PREM. $ ___________

LAST LIFE INSURANCE APP. YEAR _______ COMPANY _______________________ ACTION ____________________________________

OCCUPATION _______________________________________ / MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

FAMILY HISTORY: AGE, IF STILL LIVING: FATHER ________ MOTHER ________ SIBLING 1 ________ SIBLING 2 _______ SIBLING 3 _______

IF ANY DECEASED, GIVE RELATION(S), AGE(S) AND CAUSE(S) ____

DRIVING RECORD: # OF VIOLATIONS IN PAST 3 YEARS _____________ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____________

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK ❑ NO ❑ YES, DETAILS ____

DATE OF LAST MEDICAL CHECKUP __________ / DATE OF LAST EKG ___________ AND RESULTS _____________________________

LAST BLOOD PRESSURE READING (RESULTS) ____________/____________ / ARE YOU TREATED FOR BLOOD PRESSURE ❑ NO ❑ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____________, ____________ TREATED FOR CHOLESTEROL ❑ NO ❑ YES

AGENT: NAME ____ PHONE ______________________ FAX ____________________

ADDRESS ____ CITY ____________________ ST ______ ZIP ____________

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION ____ FAX ___________________

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1. TYPE OF LUNG DISEASE

❑ CHRONIC BRONCHITIS
❑ EMPHYSEMA
❑ RESTRICTIVE LUNG DISEASE
❑ ASTHMA

2. PLEASE LIST DATE WHEN FIRST DIAGNOSED ____________

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

❑ NO ❑ YES, PLEASE GIVE DATE _______________________

4. HAS THE CLIENT EVER SMOKED?

❑ YES, CURRENTLY SMOKES ______________ (AMOUNT/DAY)

❑ YES, SMOKED IN THE PAST BUT QUIT ____________ (DATE)

❑ NO, NEVER SMOKED

5. IS YOUR CLIENT ON ANY MEDICATION, AN INHALER, OR OXYGEN TANK FOR THE DISEASE?

❑ NO ❑ YES, DETAILS ________________________________

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6. HAS THE CLIENT HAD A RECENT PULMONARY FUNCTION (BREATHING TEST)?

❑ NO ❑ YES, PLEASE GIVE RESULTS ___________________

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON AN ACG OR X-RAY?

❑ NO ❑ YES, PLEASE DETAIL __________________________

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8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY), ALONG WITH ALL MEDS AND VITAMINS TAKEN, INCLUDE DOSAGE AND FREQUENCY:

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