

QUICK QUOTE FOR CORONARY BYPASS

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, AGE AND CAUSE, OF EACH _____

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 _____

1. WHEN WAS THE BYPASS SURGERY PERFORMED:
MONTH _____ YEAR _____

IF A SECOND BYPASS WAS PERFORMED:
MONTH _____ YEAR _____

2. CLIENT'S AGE WHEN BYPASS WAS PERFORMED _____
IF 2ND BYPASS, CLIENT'S AGE AT THAT TIME _____

3. HOW MANY GRAFTS WERE PERFORMED?
 1 2 3 4 5 6 OR MORE

IF SECOND PROCEDURE, HOW MANY GRAFTS PERFORMED:
 1 2 3 4 5 6 OR MORE

4. INDICATE THE TYPE OF GRAFT(S) USED:
 SAPHENOUS VEIN (FROM LEGS)
 INTERNAL MAMMARY ARTERY
 BOTH
IF THERE WAS ANGIOPLASTY DONE IN ADDITION TO BYPASS SURGERY, PLEASE CONTINUE WITH QUESTION #5, IF NOT, SKIP TO QUESTION #8

5. WHEN WAS THE CORONARY ANGIOPLASTY PERFORMED?
MONTH _____ YEAR _____

IF A SECOND ANGIOPLASTY WAS PERFORMED:
MONTH _____ YEAR _____

6. HOW MANY ARTERIES WAS THE PROCEDURE PERFORMED ON? 1 2 3 4 5 6 OR MORE

7. WHICH CONDITIONS PRECEDED THE ANGIOPLASTY OR BYPASS (PLEASE CHECK ALL THAT APPLY):

HEART ATTACK
 CHEST PAIN
 IRREGULAR STRESS EKG
 EXTREME FATIGUE
 OTHER _____

8. SINCE THE TIME OF THE ANGIOPLASTY OR BYPASS, HAS THE CLIENT EXPERIENCED EITHER OF THE FOLLOWING:

CHEST PAIN
 IRREGULAR STRESS EKG

9. DATE OF LAST:

<input type="checkbox"/> RESTING EKG	DATE	_____
	RESULTS	_____
<input type="checkbox"/> STRESS TEST	DATE	_____
	RESULTS	_____
<input type="checkbox"/> NUCLEAR STRESS TEST	DATE	_____
	RESULTS	_____
<input type="checkbox"/> STRESS ECHO	DATE	_____
	RESULTS	_____

10. 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):

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.