

# CPS QUICK QUOTE FOR DEPRESSION

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

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**CPS OFFICE ONLY:** ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. CLIENT HAS BEEN DIGNOSED AS:

- HAVING DEPRESSION
- BEING MANIC DEPRESSIVE (BIPOLAR)

2. HAS CLIENT EVER ATTEMPTED SUICIDE?

- NO  YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

3. HAS CLIENT EVER BEEN HOSPITALIZED FOR DEPRESSION?

- NO  YES, PLEASE DETAIL:

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

4. DURING THE PAST 12 MONTHS, HAS THE CLIENT MISSED WORK DUE TO DEPRESSION?

- NO  YES, PLEASE DETAIL NUMBER OF OCCASIONS AND TIME MISSED:

\_\_\_\_\_  
\_\_\_\_\_

5. IS CLIENT CURRENTLY TAKING MEDICATION FOR DEPRESSION?

- NO  YES, PLEASE DETAIL TYPE AND DOSAGE:

\_\_\_\_\_

6. IS CLIENT CURRENTLY SEEING OR HAS HE/SHE SEEN A MENTAL HEALTH THERAPIST?

- NO  NOT CURRENTLY  YES

IF YES OR NOT CURRENTLY, PLEASE DETAIL HOW OFTEN, FOR HOW LONG, AND THE DATE OF THE LAST VISIT:

\_\_\_\_\_  
\_\_\_\_\_

7. IS CLIENT CURRENTLY RECEIVING, OR IN THE PAST RECEIVED, DISABILITY BENEFITS DUE TO DEPRESSION OR OTHER DISABILITY?

- NO  YES, PLEASE DETAIL START AND END DATES:

START: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

END: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

- YES, CLIENT IS STILL GETTING BENEFITS

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

\_\_\_\_\_  
\_\_\_\_\_