

CPS QUICK QUOTE FOR DIABETES

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, 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. CLIENT'S AGE AT ONSET OF DIABETES _____

2. WHAT IS THE METHOD OF CONTROL?

- DIET ONLY
- DIET AND ORAL MEDICATION(S)*
- DIET AND INSULIN INJECTION

*LIST MEDICATIONS _____

3. HAS CLIENT ALWAYS BEEN ON INSULIN?

- YES NO, IF NOT, LENGTH OF TIME ON INSULIN _____

4. HOW MANY TIMES PER DAY IS INSULIN ADMINISTERED?

- ONE OR TWO TIMES PER DAY
- THREE OR MORE TIMES PER DAY
- INSULIN PUMP

5. HOW OFTEN ARE BLOOD SUGAR LEVELS MONITORED?

- ONE OR TWO TIMES PER DAY
- THREE OR MORE TIMES PER DAY

6. PLEASE NOTE ANY/ALL OF THE FOLLOWING EXPERIENCED:

- EKG ABNORMALITIES
- INSULIN REACTIONS
- DIABETIC COMA
- EYE TROUBLE
- HEART TROUBLE
- PROTEIN IN URINE
- SKIN ULCERATION
- AMPUTATIONS
- NEUROPATHY OR LOSS OF FEELING

OTHER _____

7. PLEASE DETAIL ANY INDICATIONS FROM QUESTION #6, SUCH AS: TYPE OF, DATE OF, FREQUENCY OF OCCURRENCE:

8. HAS CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?

- NO YES, PLEASE DETAIL LEVEL: _____ ENTER VALUE OF 0.0 - 15.0 (NORMAL RANGE OF LESS THAN 6.5 = EXCELLENT CONTROL; VALUES GREATER THAN 10.0 = POOR CONTROL)

9. HOW LONG HAS GLYCOHEMOGLOBIN LEVEL REMAINED CONSTANT?

- 0 TO 6 MONTHS
- 6 TO 12 MONTHS
- OVER A YEAR

10. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

- 0 TO 6 MONTHS
- 6 TO 12 MONTHS
- OVER A YEAR

11. 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):
