

QUICK QUOTE FOR HEPATITIS (Elevated Liver Functions)

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. PLEASE LIST DATE AND RESULTS OF CLIENT'S TWO MOST RECENT LIVER FUNCTION TESTS:

	RESULT	DATE#1	RESULT	DATE#2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____
HBV PCR	_____	_____	_____	_____
HCV PCR	_____	_____	_____	_____

2. CHECK TYPE, AND LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

- A DATE _____ NEG POS
- B DATE _____ NEG POS
- C DATE _____ NEG POS

3. HAS THE CLIENT HAD A LIVER BIOPSY?
 NO YES, DETAIL DATE AND RESULTS _____

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH (CHECK AND DETAIL ANY/ALL THAT APPLY):

- FATTY LIVER, DETAILS _____
- HEPATITIS, TYPE:
 ACUTE CHRONIC ACTIVE CHRONIC PERSISTENT
 DETAILS _____
- CIRRHOSIS, DETAILS _____

5. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?
 NO YES, DETAIL FREQUENCY AND AMOUNT: _____

IF NO, DATE OF LAST DRINK: MONTH _____ YEAR _____

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

- 0 TO 6 MONTHS AGO
 6 TO 12 MONTHS AGO
 12 TO 24 MONTHS AGO
 OVER 2 YEARS AGO

7. 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.