INSURANCE SERVICES SINCE 1974

COMPANIES • PRODUCTS • SERVICE

QUICK QUOTE FOR CANCER

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) ____________________

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

DATE OF LAST MEDICAL CHECKUP __________ / DATE OF LAST EKG __________ AND RESULTS ____________________

AGENT: NAME ____________________ PHONE ______________ FAX ______________

ADDRESS ____________________ CITY ______________ ST _____ ZIP __________

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION ____________________ FAX ______________

1. TYPE OF MALIGNANCY OR CANCER?
❑ BLADDER
❑ BREAST
❑ CERVICAL
❑ COLON OR RECTAL (ALSO COMPLETE QUESTION #4)
❑ HODGKIN'S DISEASE
❑ MELANOMA (ALSO COMPLETE QUESTION #5)
❑ PROSTATE (ALSO COMPLETE QUESTION #9)
❑ SKIN (ALSO COMPLETE QUESTION #5)
❑ OTHER ____________________

2. HAS TUMOR OR MALIGNANCY METASTASIZED?
❑YES ❑NO, PLEASE DETAIL:

DATE DIAGNOSED: MONTH ____________ YEAR ________

3. STAGE OF TUMOR OR MALIGNANCY: T ___ N ___ M ___
(INCLUDE PATHOLOGY REPORT IF AVAILABLE)

OR ❑ 1 ❑ 2 ❑ 2A ❑ 2B ❑ 3 ❑ 3A ❑ 3B ❑ 4 ❑ 5

❑ OTHER ____________________

4. DUKE'S SCALE **(FOR COLON OR RECTAL CANCER ONLY)**:

❑ A1 ❑ B1 ❑ B2 ❑ C1 ❑ C2 ❑ D

5. CLARK'S LEVEL **(FOR MELANOMA ONLY)**:

❑ I ❑ II ❑ III ❑ IV ❑ V

TYPE ____________________

LOCATION ON BODY ____________________

DEPTH OF MELANOMA ____________________

6. TYPES OF TREATMENT USED (CHECK ALL APPLICABLE):

❑ SURGICAL REMOVAL OF MALIGNANCY
❑ CHEMOTHERAPY
❑ RADIATION THERAPY
❑ HORMONAL (ORCHIDECTOMY - DES. LUPRON)
❑ OTHER ____________________

7. DATE OF LAST TREATMENT RECEIVED ______________

8. HAS THERE BEEN ANY MEDICAL EVIDENCE OF RECURRENT CANCER?
❑ NO ❑ YES, PLEASE DETAIL DATE AND OCCURRENCE

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9. **FOR PROSTATE CANCER ONLY**:
(INCLUDE PATHOLOGY REPORT IF AVAILABLE)

STAGE: T ___ N ___ M ___

OR ❑ A1 ❑ A2 ❑ B1 ❑ B2 ❑ C1 ❑ C2 ❑ D

GLEASON'S GRADE: ❑ 2 OR 3 ❑ 4 OR 5 ❑ 6 OR MORE

RESULTS OF MOST RECENT PSA TEST ______________

PSA RESULTS PRIOR TO TREATMENT ______________

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:

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