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.

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 _____

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? IF NOT, PROVIDE LENGTH OF TIME ON INSULIN?

_____

4. HOW MANY TIMES A 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 INDICATE ANY 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 THE CLIENT HAD A GLYCOHEMOGLOBIN (A1C) TEST DURING THE PAST SIX MONTHS?

❑ NO ❑ YES, PLEASE DETAIL LEVEL:

_____ Please enter the value (0.0 – 15.0)
(Normal range <6.5 – excellent control; values >10.0 poor control)

9. HOW LONG HAS THE 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 AGO
❑ 6 TO 12 MONTHS AGO
❑ OVER 1 YEAR AGO

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:

_____

_____

_____