INSURANCE SERVICES SINCE 1974

COMPANIES • PRODUCTS • SERVICE

QUICK QUOTE FOR HEART CONDITIONS

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) ____

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 _____________________

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1. THE CLIENT'S HEART CONDITION / DIAGNOSIS IS:

❑ HEART MURMUR: TYPE ________________ GRADE _______
❑ CARDIOMYOPATHY:
TYPE: ❑ CONGESTIVE
❑ RESTRICTIVE
❑ ASYMMETRIC SEPTAL HYPERTROPHY
❑ IDIOPATHIC HYPERTROPHY SUB-AORTIC STENOSIS
❑ CARDIAC ENLARGEMENT / LEFT VENTRICLE HYPERTROPHY
❑ ARRYTHMIAS:
TYPE _________________________________
❑ CONGESTIVE HEART FAILURE
❑ CHEST PAINS
❑ OTHER _____________________________________

2. DATE DIAGNOSED __________ DATE RESOLVED __________

3. ARE THERE ANY CURRENT SYMPTOMS?

❑ NO ❑ YES, PLEASE DETAIL ___________________________

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4. WHAT TREATMENTS HAVE BEEN PRESCRIBED?

❑ MEDICATIONS, PLEASE LIST ___________________________

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❑ PACEMAKER, START DATE _____________________________

❑ SURGERY, PLEASE DETAIL TYPE AND DATE _____________

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5. DOES CLIENT WORK FULLTIME? ❑ YES ❑ NO

6. WHAT TESTS HAVE BEEN PERFORMED?

❑ RESTING EKG
DATE AND RESULTS ____________________________
❑ EXERCISE EKG
DATE AND RESULTS ____________________________
❑ THALLIUM TEST
DATE AND RESULTS ____________________________
❑ STRESS ECHOCARDIOGRAM
DATE AND RESULTS ____________________________
❑ CORONARY CATHETERIZATION
DATE AND RESULTS ____________________________

7. WHAT IS THE EJECTION FRACTION? ______________________

8 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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