QUICK QUOTE FOR ULCERATIVE COLITIS & CROHN'S DISEASE

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) _____

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 NOTE TYPE OF INFLAMMATORY BOWEL DISEASE PRESENT:

❑ CHRONIC ULCERATIVE COLITIS
❑ CHRONIC PROCTITIS
❑ CROHN'S DISEASE

2. PLEASE LIST DATE OF ONSET _____

3. PLEASE NOTE SEVERITY:

❑ MILD (UP TO 4 WEEKS DURATION, MAXIMUM 1 ATTACK PER YEAR)
❑ MODERATE (4 TO 6 WEEKS DURATION, 2 ATTACKS PER YEAR)
❑ SEVERE (OVER 6 WEEKS DURATION, 3 OR MORE ATTACKS PER YEAR)

4. PLEASE NOTE LOCATION(S) OF ULCERATIVE COLITIS:

❑ LARGE COLON
❑ SMALL BOWEL
❑ RECTUM ONLY (PROCTITIS)

5. DATE OF LAST ATTACK OR BOUT _____

6. PLEASE DETAIL TREATMENT INVOLVED (CHECK AND DETAIL FOR ALL THAT APPLY):

❑ MEDICATION, TYPE AND DOSAGE _____

❑ SURGERY

❑ RESECTION WITH TOTAL COLECTOMY, DATE _____

❑ RESECTION WITH PARTIAL COLECTOMY, DATE _____

❑ HOSPITALIZATION, DATE _____

7. PLEASE NOTE ALL OTHER RELATED COMPLICATIONS OR IMPAIRMENTS (CHECK ALL THAT APPLY):

❑ LIVER DISORDER OR ELEVATED LIVER FUNCTION TESTS
❑ ANEMIA
❑ GASTROINTESTINAL BLEEDING
❑ TRANSFUSIONS
❑ ARTHRITIS

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 REQUENCY:

_____

_____

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