CPS INSURANCE SERVICES

QUICK QUOTE FOR DIABETES

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, PROVIDE RELATION, AGE AND CAUSE OF DEATH _____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET_____

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 _____ RESULTS _____

DATE OF LAST RESTING EKG _____ RESULTS_____

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) _____/ ARE YOU TREATED FOR BLOOD PRESSURE? ☐NO ☐YES

LAST TOTAL CHOLESTEROL READING AND HDL READING _____/ARE YOU TREATED FOR CHOLESTEROL? ☐NO ☐YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

CPS OFFICE ONLY: ENTER OFFICE NAME/LOCATION _____ FAX _____

1. DATE DIAGNOSED WITH DIABETES: _____

2. SPECIFY TYPE OF DIABETES:

☐ TYPE 1
☐TYPE 2

3. HOW IS YOUR DIABETES TREATED?:

☐ DIET ONLY ☐ ORAL MEDICATION(S)*
☐ INSULIN INJECTION * ☐ INSULIN PUMP*

*LIST UNITS OF INSULIN OR MEDICATION(S) AND DOSAGE:

_____

4. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?
CHECK ALL THAT APPLY AND INCLUDE DATES:

☐ EKG ABNORMALITIES_____
☐ INSULIN REACTIONS _____
☐ DIABETIC COMA _____
☐ EYE TROUBLE (RETINOPATHY)_____
☐ HEART TROUBLE _____
☐ PROTEIN/MICROALBUMIN IN URINE (NEPHROPATHY)_____
☐ SKIN ULCERATION_____
☐ AMPUTATIONS _____
☐ LOSS OF FEELING(NEUROPATHY) _____
☐ OTHER _____

5. PROVIDE MOST RECENT HEMOGLOBIN A1c LEVELS:

DATE AND RESULT _____
DATE AND RESULT _____
DATE AND RESULT _____

6. PROVIDE MOST RECENT MICROALBUMIN RESULT, IF AVAILABLE (THIS IS A URINE TEST FOR PROTEIN):

_____

7. DATE OF YOUR LAST VISIT TO A PHYSICIAN AND RESULTS:

_____

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS:

_____

_____